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ASSISTED SUICIDE IN THE UNITED STATES

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Assisted Suicide in the United Stat...

HEARING

BEFORE THE

SUBCOMMITTEE ON THE CONSTITUTION

OF THE

COMMITTEE ON THE JUDICIARY

HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

APRIL 29, 1996

Serial No. 78

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HOUSE OF REPRESENTATIVES
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APRIL 29, 1996

Serial No. 78



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ASSISTED SUICIDE IN THE UNITED STATES

THURSDAY, APRIL 29, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON THE CONSTITUTION
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 1 p.m., in room 2237, Rayburn House Office Building, Hon. Charles T. Canady (chairman of the subcommittee) presiding.

Present: Representatives Charles T. Canady, Henry J. Hyde, and Barney Frank.

Also present: Keri D. Harrison, assistant counsel; Jacqueline McKee, paralegal; Mark Carroll, staff assistant; and Robert Raben, minority counsel.

OPENING STATEMENT OF CHAIRMAN CANADY

Mr. CANADY. The subcommittee will come to order.

Currently 35 States have statutes prohibiting assisted suicide. An additional 8 States recognize assisted suicide as a common law crime. These criminal prohibitions show the value States place on the protection of human life and the serious threat that assisted suicide poses to respect for life in the United States and to the safety of vulnerable persons.

Compassion in Dying v. *State of Washington* and *Quill* v. *Vacco* decided by the ninth and second circuit courts of appeal, respectively, held that assisted suicide is a constitutional right for competent, terminally ill persons.

On March 6, 1996, in *Compassion in Dying*, the ninth circuit found a liberty interest in determining the time and manner of one's own death. The court held "that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by the terminally ill who wish to hasten their own deaths, it violates the due process clause of the 14th amendment." In other words, the court decided that assisted suicide is a fundamental right.

On April 2, 1996, in the *Quill* case, the second circuit court struck down New York statutes prohibiting assisted suicide as violative of the equal protection clause of the 14th amendment. The court found that the New York law did not treat similarly situated persons alike. The court stated that "those in the final stages of terminal illness are allowed to hasten their deaths by the removal of such systems, but those who are similarly situated except for the previous attachment of life-sustaining equipment are not allowed to hasten death by self-administered prescribed drugs."

Not only did the court decide the New York statutes were not rationally related to any legitimate State interest, but the court determined that the State had no interest in prolonging a life that was soon to end. The court asked the question: "But what interest can the State possibly have in requiring the prolongation of a life that is all but ended?" The court then answered its own question: "None."

Interestingly, unlike the ninth circuit, the majority in the second circuit refused to call assisted suicide a fundamental right.

I am disturbed by the decisions of the ninth and second circuit courts of appeals. With no national debate, these courts are attempting to implement a broad public policy that would profoundly affect the way Americans deal with life and death and drastically alter the role of physicians in our society. It is my hope that the Supreme Court will hear these cases and overturn these dangerous decisions.

Legalizing physician-assisted suicide or any other practice designed to kill innocent human beings would result in abandoning to death those in our society who are most vulnerable. Cloaking such practices with the protection of the Constitution would be yet another blow against respect for life in our land.

Today we will hear from three panels of witnesses. They will testify about the medical, legal, and ethical issues surrounding assisted suicide in the United States. I want to express the subcommittee's appreciation to each of the witnesses testifying today.

I must also express my disappointment that the administration has declined our invitation to participate in today's hearing. President Clinton has declared his opposition to legalizing assisted suicide. When asked in 1992 about legislation to allow assisted suicide, he stated, "I certainly would do what I could to oppose it."

The spokeswoman for the President recently reaffirmed his opposition to assisted suicide in the Washington Times. She told the Times, "On the political side, there are a lot of issues on which Mr. Clinton agrees with the Catholic Church," and then cited opposition to assisted suicide as one of those issues.

Unfortunately, the Department of Justice and the White House both declined invitations to testify at this hearing. But in a letter from the White House, which I will place in the record, the Director of Legislative Affairs for the White House reiterated that the President opposes assisted suicide.

[The letter follows:]

THE WHITE HOUSE
WASHINGTON
April 26, 1996

Dear Mr. Chairman:

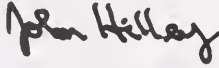
I appreciate your letter of April 22, 1996 inviting a representative of the President to testify before your Subcommittee during its April 29th hearing on "Assisted Suicide in the United States." I also understand that Judiciary Committee Chairman Hyde extended a similar invitation to Attorney General Janet Reno. Generally, because this Administration strongly believes in the value and importance of the Congressional hearing process, we endeavor to accommodate each request for testimony or assistance.

There are times, however, when circumstances dictate that Administration testimony be withheld until a more appropriate time. The President has clearly expressed his personal opposition to assisted suicide, and he remains of that view. Nevertheless, after consulting with both the White House Counsel Jack Quinn and Assistant Attorney General Walter Dellinger, I believe this is one of those rare occasions when the Administration must respectfully decline the Committee's invitation.

Your staff informs us that two recent assisted suicide cases, Quill v. Vacco and Compassion in Dying v. State of Washington, decided by the 2nd and 9th Circuit Courts of Appeal, respectively, will be the primary focus of the April 29th hearing. It is anticipated, therefore, that any Administration witness would be expected to, and indeed should be prepared to, comment on those decisions. The Administration has not had occasion to address the constitutional issues that dictated the courts' decisions in those cases and which are of primary interest to your Subcommittee. Additionally, many legal experts believe the U.S. Supreme Court will consider either or both of these cases later this year or early next year. If that is so, any Administration position on the relevant constitutional issues may be developed in connection with a decision by the Solicitor General to file amicus briefs in these cases.

As these issues are resolved, I hope this Administration is afforded an opportunity, when and as appropriate, to address these important constitutional issues or to provide comment on any legislation that your Subcommittee may develop on this issue.

With Best Regards,

A handwritten signature in dark ink, appearing to read "John Hilley". The signature is fluid and cursive, with the first name "John" and last name "Hilley" clearly distinguishable.

John Hilley
Assistant to the President and
Director of Legislative Affairs

The Honorable Charles T. Canady
Chairman, Subcommittee on the Constitution
Committee on the Judiciary
362 Ford House Office Building
Washington, D.C. 20515

Mr. CANADY. It is my hope that the President will put his words into action by directing the Solicitor General to file briefs urging the Supreme Court to consider the two U.S. courts of appeals cases which are the subject of discussion here today.

[Correspondence follows:]

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April 16, 1996

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The Honorable Janet Reno
Attorney General
U.S. Department of Justice
Main Justice Building
10th and Constitution Avenue, N.W.
Washington, D.C. 20530

Dear Attorney General Reno:

The Subcommittee on the Constitution is planning to hold an Oversight Hearing on assisted suicide. The hearing will be held on Monday, April 29, 1996 at 1:00 p.m. in room 2237 of the Rayburn House Office Building.

I would like to formally invite you or your representative to appear and testify at the hearing. Please forward one-hundred (100) copies of your prepared statement no later than 1:00 p.m. on Thursday, April 25, 1996 to the following address:

Subcommittee on the Constitution
362 Ford HOB
Washington, D.C. 20515

Also, the Subcommittee puts prepared statements for hearings on the Internet to allow access to the public. To that end, providing a diskette with your prepared statements would be greatly appreciated (Wordperfect 5.1, 3.5 inch diskette).

If you have any questions or comments, please do not hesitate to contact the Subcommittee at (202) 226-7680.

Acceptance of this invitation at your earliest opportunity is greatly appreciated.

Sincerely,


HENRY J. HYDE
Chairman

HJH/mc

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ONE HUNDRED FOURTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON THE JUDICIARY

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MINORITY STAFF DIRECTOR
 JULIAN EPSTEIN

Mr. John Hilley
 Assistant to the President
 and Director for Legislative Affairs
 The White House
 West Wing, Second Floor
 Washington, D.C. 20502

Dear Mr. Hilley:

The Subcommittee on the Constitution is planning to hold an Oversight Hearing on "Assisted Suicide in the United States." The hearing will be held on Monday, April 29, 1996 at 1:00 p.m. in room 2237 of the Rayburn House Office Building.

I would like to invite a representative of the President to appear and testify at the hearing. The President has recognized the threat that assisted suicide poses to vulnerable persons and declared his opposition to legalizing assisted suicide. When asked in 1992 about legislation to allow assisted suicide, he stated, "I certainly would do what I could to oppose it" ("Clinton Bashers No-Show Bush; On T.V. Later, He Calls Assisted Suicide Wrong," *Detroit Free Press*, Sept. 23, 1992). Mary Ellen Glynn, a spokeswoman for the President, recently reaffirmed his opposition to assisted suicide in *The Washington Times*. She said, "On the political side, there are a lot of issues on which Mr. Clinton agrees with the Catholic Church," and then cited opposition to assisted suicide as one of those issues ("Cardinals hit Clinton on Abortion," *The Washington Times*, April 17, 1996).

The Committee invited Attorney General Janet Reno to the hearing, but, unfortunately, the Department of Justice decided not to send a representative. My staff was told that Assistant Attorney General Walter Dellinger said the Justice Department had no position on assisted suicide. As the Department of Justice has declined Chairman Hyde's invitation, I would greatly appreciate if the White House would send a representative to express the President's views.

Thank you in advance for accepting this invitation at your earliest opportunity. If you have any questions, please contact the Subcommittee at (202) 226-7680.

Sincerely yours,

Chas. T. Canady

Charles T. Canady
Chairman
Subcommittee on the Constitution

Mr. CANADY. Mr. Hyde.

Mr. HYDE. Thank you, Mr. Chairman, for having the initiative to hold these hearings. These are all subjects people detest talking about and thinking about, but at the pain of not doing your duty if we don't think about them. I congratulate you for doing this.

I think America, especially in view of the two cases that you speak of from the ninth circuit and second circuit, is on the threshold of something, I guess, called the culture of death. The autonomous individual, which is the articulated creature of the *Casey* decision, is preeminent. And I think when we are finished going in this direction, we should amend our Declaration of Independence and talk about the inalienable right to life and death, liberty, the pursuit of happiness in this or the next world. But we have too much emphasis on life and liberty in our Declaration and our other foundational documents.

The slippery slope that some of us warned about back in 1973 when the Supreme Court sanctified abortion as another "choice," a legitimate option—indeed, a preferred option the way things have worked out. Some of us warned of a slippery slope—that has become a precipitous plunge off a cliff.

It takes too much time to go down a slippery slope. Pressures are going to develop. They are already under way. Some are a sounding for older people to get out of the way. Get out of the way. Your usefulness is over. You are useless. Where have I heard that phrase before?

Sanctity of life is going to be a joke. It is a joke. It is something that only religious kooks hold to or utter.

So we are on the threshold of enormous changes in our philosophy and the way we look at human life. And they are the progeny of—you should pardon the expression—of *Roe v. Wade*, the *Casey* case, and the rest.

We get into fascinating questions about whether a patient who is incompetent, suffering from Alzheimer's, or has a stroke, or is unconscious, whether the autonomy of that person can be divested and vested in the caregiver, who then can say, "Give my ward the injection."

We are on the threshold of scientific people saying there is no difference between withholding treatment and affirmatively killing somebody, all of which diminishes, again, that old-fashioned term, "the sanctity of life." This is where being a Congressman is interesting, really, really interesting. You come to grips with these ideas, and they are critical.

So I thank you again, Mr. Chairman, for holding these hearings, and I will await with interest the testimony.

Mr. CANADY. Thank you, Mr. Hyde.

Our first witness in today's discussion of assisted suicide is Dr. Kathleen Foley. Dr. Foley is chief of the pain service in the department of neurology at Memorial Sloan-Kettering Cancer Center. She is also currently serving as the Open Justice Institute project director for the Project on Death in America.

Next we will hear testimony from Dr. Timothy Quill. Dr. Quill is a professor of medicine and psychiatry at the University of Rochester School of Medicine. He was a lead physician plaintiff in the

second circuit case of *Quill v. Vacco*, which challenged the New York law prohibiting assisted suicide.

Following Dr. Quill will be Diane Coleman. Ms. Coleman has served on the California Attorney General's Commission on Disability as well as the board of directors of the West Side Center for Independent Living. She is also the author of many articles concerning the issue of independent living.

Next to testify will be Dr. Samuel Klagsbrun. Dr. Klagsbrun is the executive medical director and owner of the Four Winds Hospital in Katonah, NY. Dr. Klagsbrun was also a plaintiff in the *Quill* case.

The final witnesses on the first panel will be Dr. Herbert Hendin. Dr. Hendin is the executive director of the American Suicide Foundation. More than 30 of his professional articles and four of his books have dealt with suicide.

I thank all of you for being with us here today. Without objection, your full statements will be made a part of the record. I would ask that each of you summarize your testimony in no more than 5 minutes.

Dr. Foley.

STATEMENT OF KATHLEEN M. FOLEY, M.D., DIRECTOR, OPEN SOCIETY INSTITUTE'S PROJECT ON DEATH IN AMERICA

Dr. FOLEY. Thank you, Mr. Chairman. I wish to offer my sincere thanks for this opportunity to appear before this committee.

This testimony is based on my clinical experience in caring for cancer patients with pain and advanced disease for the past 21 years from a very broad clinical research program attempting to address the needs of patients with advanced disease for clinical care.

In my clinical practice I have been asked by patients to aid them in death because of severe pain. I have had the opportunity to see these requests for aid in death, psychological support, provision of family support, and with the promise that their symptoms would be controlled throughout the dying process.

The main thrust of my testimony is based on the construct that we need to move the current debate from its very narrow debate on the legalization of physician-assisted suicide to the much broader issue that concerns the American public, the need to improve the care of dying. To do so, we really must encourage a national dialog.

We need to address the public's questions: How will I die? Where will I die? Who will care for me? Will my pain be controlled? Will my values be preserved to facilitate the quality of my life at the end of my life? What are my options for care, and how will my care be paid for? Who will help the caregivers? Will my cultural, religious, and spiritual beliefs be respected?

I would like to begin by suggesting that the U.S. Government respond to the recommendations of the World Health Organization expert panel, which I chaired, which requested that member states follow the recommendations published in their technical report which was entitled, "Cancer Pain Relief and Other Care."

The recommendations were that governments around the world, specifically the United States, establish national health care policies and programs for pain relief and care; that the Government

should ensure that such programs be incorporated into existing health care systems; that member states not consider legalizing physician-assisted suicide and euthanasia until they have provided programs for their citizens for pain relief.

Based on these WHO recommendations, the Judiciary Committee should engage the public in broad discussions to understand the impact: What are the medical, legal, social, and economic barriers to the care of the dying?

Almost 2.3 million Americans die each year. We have little information on how these patients die, and we have only very general information of the place of their death. The majority of patients dying are dying in hospitals, with approximately 16 percent in nursing homes and the remainder dying either in home or in hospice programs.

There is data to suggest that cancer patients, patients with AIDS, and patients with neurological disease represent the major medical populations who can identify these potential candidates for physician-assisted suicide. Yet there is now overwhelming data to suggest that these patients—that for these patients, physicians are inadequately trained to care for them and deterred economically from providing humane, adequate care for this group of patients.

For example, 70 to 90 percent of patients with advanced cancer have pain that can be relieved, but it is not; 25 percent have major depressions that can be treated, but both physicians and nurses caring for these patients do not have the current knowledge to either identify nor, importantly, to treat them.

The average cancer patient has four symptoms that interfere with the quality of life. These, too, can be treated with the currently available approaches.

So in short, we have sufficient knowledge to improve patient care, but teaching about how to care for the dying is not a priority; providing care for the dying is not a priority.

We need, however, to not only educate professionals, we need to educate the public to understand what, in fact, their options are. Moreover, we need to provide them with options to die at home, to die with care and their medications in an affordable and available way.

At the present time, hospice care has demonstrated that it can be a cost-effective system. Yet it is only limited to about 30 to 40 percent of cancer deaths and less than 30 percent of AIDS deaths. Of 10 percent of the Oregon citizens, only 10 percent know what a hospice is when they go to physician-assisted suicide. This results, in general, in the public viewing assisted suicide as their only option, and it emphasizes clearly their concept of patient autonomy, and currently proposed law provides a false sense of autonomy.

The laws only provide protection for physicians to allow them to write a prescription. They do not ensure that patients will have access to expertise in care. They do not assure the physicians will be available to them on a 24-hour basis to provide house calls, to provide home care, or to provide home care nurses or appropriate medication, and, most of all, they will not be made destitute in providing such care.

Real autonomy at the end of life can only be realized when a full range of treatments is available and affordable and patients understand their options. It is conceivable that it will be easier for a doctor to prescribe legal medications than it will be to care for the dying patient. It will equally be conceivable that these families will be left destitute in providing such care for individuals.

There is a concern that patients without families or friends or those that come from socially disadvantaged groups will, in fact, be significantly hurt by such legislation. In the current climate without universal access to care, such laws place the dying, who are our most vulnerable citizens, at a disadvantage. There needs to be an easier way to limit excessive health care cost.

In summary, there are serious flaws in our current health care system that impact on the quality of care provided to patients who are dying. It seems ironic that at a time when we have refused to guarantee health care to everyone, the judiciary selected physician-assisted suicide as the one health care right that deserves constitutionality status.

Thank you.

[The prepared statement of Dr. Foley follows:]

**PREPARED STATEMENT OF KATHLEEN M. FOLEY, M.D., DIRECTOR, OPEN SOCIETY
INSTITUTE'S PROJECT ON DEATH IN AMERICA**

Mr. Chairman and Committee Members: I wish to offer my sincere thanks for this opportunity to appear before this Committee.

I am Dr. Kathleen M. Foley, Chief of the Pain Service at Memorial Sloan-Kettering Cancer Center, and Professor of Neurology, Neuroscience and Clinical Pharmacology at Cornell University Medical College. I am the Medical Director of the Supportive Care Program in the Department of Neurology at Memorial Sloan-Kettering Cancer Center and the Director of the World Health Organization Collaborating Center for Cancer Pain Research and Education. I am also the Director of the Open Society Institute's Project on Death In America.

The testimony is based on both my clinical experience in caring for cancer patients with pain and advanced disease for the last 21 years and from our clinical research studies in palliative care.

In my clinical practice, I have been asked by suffering patients to aid them in death because of severe pain. I have had the opportunity to see these requests for aid in death fade with adequate pain control, psychological support, provision of family support, and with the promise that their symptoms would be controlled throughout the dying process.

The main thrust of my testimony is based on the construct that we need to move the current debate from its very narrow focus on the question of the legalization of physician assisted suicide to the broader issue that concerns the American public--improvements in the care of the dying.

To do so, we must address the public's questions. "How will I die?" "Where will I die?" "Who will care for me?" "Will my pain be controlled?" "Will my values be preserved to facilitate the quality of my life at the end of my life?" "What are my options for care and how will my care be paid for?" "Who will help the caregivers?" "Will my cultural, religious and spiritual beliefs be respected?"

I would like to begin by suggesting that the United States Government respond to the recommendations of the World Health Organization Expert Panel, which I chaired, that requested that member states follow the recommendations published in the Technical Report Series #804 "Cancer Pain Relief and Palliative Care". The recommendations were that governments around the world "establish national health care policies and programs for pain relief and palliative care;

ensure that such programs be incorporated into existing health care systems; make strenuous efforts to keep fully informed of all developments in the field of pain relief, palliative care, and management of terminal disease, as the pressures for the legalization of euthanasia increase.”

To address the need to improve the care of the dying, it is important to examine the factors that are driving the physician assisted suicide debate; to understand the definitions of the terms being used in the debate; to make distinctions between currently available patients’ rights and physician assisted suicide; to examine the epidemiology of death in the United States and patient symptomatology; and to understand the existing barriers to the effective care of patients at the end of life.

Factors Driving the Physician Assisted Suicide Debate

It is well recognized that debates on physician assisted suicide and euthanasia often emerge in societies when a loss of community is perceived, and at times when individual rights assume greater importance than societal rights. The re-emergence of advocacy groups for both physician assisted suicide and euthanasia in the 1980’s and 1990’s has come from numerous factions, and multiple factors. These groups include both physician advocates and public advocacy groups, including the Hemlock Society and Compassion in Dying, to name only a few. The multiple medical, social and economic factors framing this discussion include: advancements in high technological medical support systems for patients with respiratory and cardiac failure; changes in the trajectory of dying, with large numbers of patients with cancer and AIDS alive for months and years following the diagnosis of an incurable illness; the increasing age of the population; the greater emphasis on patient autonomy; a concerted policy shift from societal to individual rights; and the highly debated limitations in health care resources, particularly for patients with chronic, incurable illness.

At the core of this debate is the issue of patient autonomy, with an increasing focus on patient-centered care, characterized by the wide use of living wills, advance directives and health care proxies to protect patients from the medical systems of physicians and hospitals who care for them. This debate requires an understanding of the complexity of the medical issues.

Definition of Terms

For the purposes of discussion, it is critical to define terms. Euthanasia is defined as the physician intentionally administering a treatment (usually medication) to cause a patient’s death, with the patient’s full informed consent. Voluntary active euthanasia is another term used to describe this action. Involuntary active euthanasia is the act of a physician to intentionally administer a treatment (usually medication) to cause the patient’s death without the patient’s full consent. The patient may be incompetent, or never asked. Physician assisted suicide is the provision of a causative agent (usually a medication) to a patient, with the intent that the patient will use the drug to commit suicide. Assisted suicide is the provision of assistance, for example, medication, carbon monoxide tanks, or various other physical or medicinal approaches, with the intent that the patient will use these agents to commit suicide. Palliative care is the active, total care of patients whose disease is not responsive to curative treatment. Suffering is described as

an aversive experience, challenged by the perception of personal distress that is generated by factors that undermine quality of life. Double effect may be defined as the administering of opioids or sedative drugs to relieve pain and suffering in a dying patient with the incidental consequence of causing either respiratory depression or extreme sedation or both, resulting in the patient's death. Rational suicide has been the term used to describe suicides in patients with advanced disease.

Ethical, Moral and Legal Distinctions

It is well recognized that there are ethical, moral and legal distinctions between physician assisted suicide and euthanasia, and withholding or withdrawing treatment from a patient that will allow him or her to die. Many states have developed a growing consensus supporting the ethics of both withdrawing and withholding life-sustaining treatments. The Supreme Court allows such medical practices in certain conditions.

In the management of patients with severe pain and suffering, the ethical principle of double effect has long been accepted by both physicians and non-physicians. This is not considered an act of either physician assisted suicide or voluntary or involuntary active euthanasia.

Numerous professional practice guidelines have established that withdrawing or withholding care, as well as the use of opioids and sedative drugs to treat pain and suffering are considered to be both ethical and legal in specific situations. However, there remains confusion among health care professionals between withholding and withdrawing of care and the use of symptom control methods to manage pain and suffering, with the concern that these approaches represent either voluntary active euthanasia or physician assisted suicide. There are a series of studies that demonstrate a lack of knowledge by physicians in understanding these ethical principles and the currently existing guidelines with such lack of knowledge impacting on appropriate care for patients at the end of life.

Epidemiology of Death in the United States

Cause of death. In 1994 there were almost 2.3 million deaths in the United States. The three leading causes of death were disease of heart (32%), malignant neoplasms (24%), and cerebrovascular disease (7%). HIV infection on an age related basis is the most common cause of death for white men between the ages between of 25 and 44.

Place of death. We have little information on how patients die and very general information on their place of death. From death certificate data, approximately 62% of the 2.3 million deaths occur in hospitals, 16% occur in nursing homes (38% of those over 85 die in nursing homes), 17% occur in homes and depending upon the age group, the rate of in-hospital deaths ranges from 48 to 91%.

Hospice Care. Data from the National Hospice Organization indicates that approximately 40% of cancer deaths in the United States occur in patients cared for by hospice programs and approximately 35-40% of deaths from AIDS occur in patients cared for by hospice.

Epidemiology of Requests for Physician Assisted Suicide

At the current time, we do not know the number of patients who request physician assisted suicide. The available surveys provide indirect information. They include the public surveys and physician surveys. Few studies have asked the dying. Two studies that have looked at suicidal ideation or a desire for death in AIDS and cancer patients have both underscored the high correlation of depression with such requests by patients.

Before considering the barriers to the effective care of the dying, it is important that the medical problems facing this population be recognized in this discussion. Cancer patients, patients with AIDS, and patients with other neurological diseases represent the major medical populations who have been identified as potential candidates for physician assisted suicide.

Prevalence of Symptoms

There is a large body of data that define the components of suffering in patients with advanced terminal disease. It is not only suffering in the patient, but also in their families and in the professional caregivers attending them. These are often highly and inextricably related. The perceived distress in any one of these groups amplifies the distress of the others. In defining a taxonomy for suffering, there are three major factors: 1) pain and physical symptoms, 2) psychological distress, and 3) existential distress. Numerous studies in both cancer and AIDS patients have demonstrated the high prevalence of physical and psychological symptoms, as well as existential distress.

- ▶ 70 to 90% of patients with advanced disease from cancer have significant pain that requires the use of opioid drugs
- ▶ severe, unrelenting pain interferes with the patients' quality of life, including their activities of daily living, their sleep, and their social interactions
- ▶ 80% of elderly patients have chronic pain
 - ▶ 66% have pain in the last month of life
 - ▶ caregivers in a survey of deaths of 1227 elderly individuals reported 33% were in pain during the 24 hours before death
- ▶ advanced cancer patients have more than 7 significant symptoms that interfere with their quality of life, such as fatigue, general weakness, dyspnea, delirium, nausea and vomiting

Concurrent with these physical symptoms have been a variety of well-described psychological symptoms.

- ▶ In a large prospective study of psychological symptoms in cancer patients, the prevalence of cancer related pain was 39% in those who had a psychiatric diagnosis, and only in 19% in those without such a diagnosis

- ▶ Psychiatric problems occur in upwards of 60% of patients with advanced cancer, with adjustment disorders, depression, anxiety and delirium being the most prominent and well described
- ▶ Studies show that some psychiatric symptoms such as anxiety and depression commonly resolve with adequate pain relief

Various factors adversely influence the prevalence and severity of psychological distress, including:

- ▶ the presence of advanced disease
- ▶ distressing physical symptoms, especially pain
- ▶ disability
- ▶ unresolved previous experiences of loss or separation
- ▶ feelings of frustration and hopelessness
- ▶ lack of perceived support from at least one loved person
- ▶ strained interpersonal relationships
- ▶ a controlling personality trait
- ▶ difficulties in adapting to illness and its implications
- ▶ economic concerns
- ▶ impaired cognitive abilities
- ▶ inadequate communication regarding illness or treatment

The prevalence of a variety of other factors that lead to distress are referred to as existential distress. Common existential issues for patients with advanced disease include:

- ▶ hopelessness
- ▶ futility
- ▶ meaninglessness
- ▶ disappointment
- ▶ remorse
- ▶ death anxiety
- ▶ disruption of personal identity

This existential distress may be related to past, present or future concerns. Current personal integrity is threatened by the variety of medical therapeutic approaches with alterations in body image, and both intellectual, social and professional function, as well as in relationships with intimacy and sexuality.

Symptom Prevalence and Suicide Vulnerability

If we look at the interface between the lack of appropriate treatment of symptoms and patients' requests for suicide, there is good evidence to suggest that these physical and psychological

symptoms are major suicide vulnerability factors for patients with both cancer and AIDS. Uncontrolled pain is recognized as a contributing factor, and persistent pain interferes with the patient's ability to receive support from families and others. The literature suggests that cancer patients with pain are vulnerable to suicide due to the increased likelihood of the presence of multiple risk factors, such as depression, delirium, loss of control, and hopelessness. Depression occurs in at least 25% of cancer patients, and up to 70% of patients with advanced disease.

- ▶ In a study by the Psychiatry Service at Memorial Sloan-Kettering Cancer Center of suicidal cancer patients, a third of patients were diagnosed with a major depression, 20% with delirium, and 50% with an adjustment disorder with anxious and depressed features at the time of evaluation.
- ▶ Suicidal ideation without intent to act occurred in 17% of 185 cancer patients with pain.

The suicidal ideation was more closely correlated with mood disturbance and degree of depression than pain. In the AIDS population, Breitbart et al reported that depression was significantly correlated with the presence of pain. HIV patients with pain were more functionally impaired, and this was highly correlated to levels of pain intensity and depression. Those patients who viewed pain as representing a threat to their health reported more intense pain than those who did not see pain as a threat. This observation suggests that the meaning of pain is particularly important in producing psychological distress. This latter group of patients were more likely to be unemployed or disabled, and reported less social support.

- ▶ In a second study, which addressed the prevalence of suicidal ideation in an ambulatory HIV infected population, and examined the relationship between suicidal ideation, depression and pain, the data demonstrated that more than 40% of those patients with pain reported suicidal ideation.

Of interest, there was no correlation between suicidal ideation and pain intensity, or pain relief. Similarly, suicidal ideation in AIDS patients with pain is more likely to be related to a concomitant mood disturbance than to the intensity of pain experienced. In fact, in the AIDS population, a prior suicide history has been noted to be the most prominent vulnerability factor.

This same data has now been demonstrated in terminally ill patients in a study by Chochinov, who looked at the desire for death in patients with far advanced disease. This data again supported the fact that there was a significant degree of depression in this population of patients, which though untreated, was yet the driving force for patient's request for physician assisted death.

Fatigue, characterized by exhaustion of physical, emotional, spiritual, financial, familial, communal, or other resources, also increases the risk for suicide in both the cancer patient and the AIDS patient. The degree to which both patient fatigue and family fatigue play a role is expressed in statements and suicide notes. Patients perceive themselves to be a burden to

themselves and to their families.

Loss of control and a sense of helplessness in the face of cancer are also important factors. Impairments or deficits induced by cancer or cancer treatments, including loss of mobility, paraplegia, loss of bowel or bladder function, amputation, aphonia, sensory loss, inability to eat or swallow, appear to increase the risk of suicide.

However, it is the loss of cognitive facilities, characterized by both delirium and disinhibition that are most closely correlated to patient successful suicide.

In short, numerous vulnerability factors have been described in patients with both cancer and AIDS, that may predict an individual at risk for suicide. These factors suggest that the profound physical and psychological symptoms experienced by this population require both appropriate assessment and treatment, because they contribute in a significant way to how patients value their living.

Rational suicide has been the term used to described suicides in patients with advanced disease. This term is, itself, controversial, and held by some to be an oxymoron. Some argue that to make a rational decision about ending one's life, a person must not be unduly influenced by overwhelming physical symptoms or mental disturbances, such as a depressive illness--important symptoms of which are hopelessness and morbid suicidal ideas. Given the complexities of the medical and psychological states of patients with advanced disease, and the dearth of trained health care professionals with expertise in the care of the dying, it is hard to believe that rational suicide is ever really rational. (See Hendin testimony)

The great concern at the present time, because of the lack of knowledge and training of American physicians in palliative care, is that physician assisted suicide might, in fact, be decided on the basis of ignorance. That, if instituted, physician assisted suicide and euthanasia would then substitute for rational therapeutic psychological and social support interventions that might enhance patients' quality of life as they die.

Barriers to Effective Care at the End of Life

Lack of Medical Education and Training. The previous section on symptoms and suicide vulnerability factors in patients with advanced disease, points up the critical reality of how sick these patients are and the magnitude of the need for a broad palliative care program that addresses their needs to maintain a quality of life at the end of their lives. There is good evidence to suggest that one of the major barriers to patients receiving appropriate end of life care is physicians' lack of knowledge and training to treat pain, other symptoms, and to assess and treat psychological and existential issues. Physicians are inadequately trained and economically deterred from providing humane compassionate care.

The dearth of professional knowledge stems in part from the lack of education in medical school, residency and fellowship training programs. This lack of knowledge is further magnified by the

lack of an institutional commitment to the care of patients at the end of life. The recently published SUPPORT data point out these existing health care systems deficits.

- ▶ The American Medical Association Liaison Committee on medical education reported that in the academic year 1993 to 1994, only five of the 126 medical schools in the United States offered a separate required course on the care of the dying. The overwhelming majority of schools used part of a larger required course to prepare medical students to treat dying patients.
- ▶ In its report on graduate medical education for 1993, the American Medical Association, using data from medical education research information, indicated that only 1851 (26%) of 7048 residency programs offered a course in the medical/legal aspects of end-of-life care as a regular part of the curriculum.
- ▶ A national survey of 1168 accredited residency programs in family medicine and internal medicine/pediatrics and fellowship programs in geriatrics revealed that in a majority of programs, residents and/or fellows coordinate the care of 10 or fewer dying patients annually, and that almost 15% of the programs offered no formal training in terminal care.
- ▶ The above survey also found that despite the availability of a hospice program, only 17% of these training programs use hospice rotations, and only half of these are required. In addition, only 9% of the programs have a resident or fellow serving as a member of a hospice team.
- ▶ In a survey of medical schools by Merriman, he concluded that the methods of teaching about death and dying, along with the attitudes within institutions, needed to be changed, to provide state of the art education on end-of-life care for all patients.
- ▶ In a study of family physicians involvement with dying patients, Steinmetz et al. concluded that physicians need formal training in death, and a way to put personal experience to use to further their learning.

This lack of medical knowledge impacts on the quality of terminal care in hospitals.

- ▶ In the study by Solomon, who surveyed 687 physicians and 759 nurses in five hospitals, 47% of all respondents and 70 percent of the house officers acknowledged that they had violated their conscience when providing care to terminally ill patients. By a ratio of four to one, respondents identified the provision of overly burdensome treatment, rather than undertreatment, as a concern.
- ▶ When asked how often they were concerned about the inappropriate use of mechanical ventilation in terminal care, 60% of medical attending physicians, 54% of surgical attending physicians and 78% of house officers indicated that they were sometimes or almost always concerned.

- ▶ Regarding cardiopulmonary resuscitation, 61% of medical attending physicians, 58% of surgical attending physicians, and 83% of house officers expressed a similar frequency of concern.
- ▶ Solomon also reported that the dominant concern of physicians and nurses about pain management was undertreatment. 85% of medical attending physicians, 83 % of surgical attending physicians and 84% of house officers indicated that the most common form of narcotic abuse in the care of the dying is the undertreatment of their pain.
- ▶ Solomon and colleagues found that undertreatment prevailed, despite the fact that 89% of medical attending physicians, 84% of surgical attending physicians and 91 % of house officers agreed that it is possible to prevent dying patients from feeling much pain.

Solomon's study points out the conflicts between practice and belief that only really can be addressed by broad public and professional education programs. Numerous surveys of medical students, nurses, physicians and state medical boards, demonstrate a significant lack of knowledge in both the theoretical and practical understanding of analgesic drug therapy in the management of cancer pain. These studies have shown physician/patient communication about pain symptoms to be problematic, with physicians consistently underestimating the patient's physical pain and overemphasizing the psychological components.

- ▶ In one study that compared cancer patient's reported pain and the concurrent observations of physicians and nurses who treated the patient, the assessment of severity by the nurse, house officer and oncology fellow differed significantly from that of the patient. with an overall correlation of only 13% for patients reporting moderate to severe pain.

These observations have been confirmed by Von Roenn, et al. who studied responses from 1177 American physicians (65% response rate) through a survey of the Eastern Cooperative Oncology Group.

- ▶ 85% of the respondents who cared for more than 70,000 cancer patients during the six months before the study agreed that the majority of cancer patients with pain were undermedicated, with poor pain assessment and lack of knowledge about analgesic drug therapy as the common barriers to adequate treatment.
- ▶ A concurrent patient study demonstrated that 42% of these physician's patients did not have their pain adequately treated.

Lack of Public Education on Options at the End of Life

Lack of Public Knowledge. This lack of knowledge, however, is not just limited to the health care professionals, but includes patients and families. Patients and families who are not fully aware of their options for care.

The public's attitude and knowledge about pain clearly demonstrates their overwhelming concern and fear of pain as a consequence of medical illness, without proper education to understand that it can be appropriately relieved. There is evidence that suggests that upwards of 90% of patients with cancer pain can have their pain effectively relieved. Yet, existing guidelines have not been implemented in practice, and are not well understood by patients. Patients are also reticent to report or to complain of pain to their physicians and they have an excessive fear of addiction. Opioid analgesic drugs are the mainstay of treatment for cancer pain, yet these are drugs that are commonly used by the addict population for mood effects. This overwhelming fear of addiction is another driving force for patients' lack of compliance with analgesic regimens.

At the present time, current federal and state laws impede physicians and patients from receiving adequate pain treatment by impacting on prescribing practices. Moreover, some state laws restrict prescribing controlled substances to certain populations, such as addicts or drug abusers, thereby raising questions about prescribing them for the drug abuse patient who develops a serious illness, including cancer. Furthermore, some archaic state laws and regulations restrict the number of doses of opioids that can be written, thereby impeding appropriate prescribing for the relief of cancer pain. Moreover, pain medications are expensive, and because they are not paid for by Medicare, these charges place undue financial burden on patients and families.

These legal barriers to effective pain control, which relate to controlled substances, are regulated at both the federal and the state level. At the federal level, they are regulated under the Controlled Substance Act and DEA regulations, but they are also regulated by State Controlled Substance Laws. At the present time, the states have had guidance from model acts in order to achieve a relatively uniform approach to regulation. Yet, there remain a number of state laws and regulations that are more restrictive than the federal law and that interfere with prescribing the necessary medication to manage pain. There are both legal and economic barriers that not only impact on patients' ability to obtain appropriate prescriptions for their pain management but to receive homecare and hospice care.

Patients also do not understand their own right to refuse treatment or to demand that physicians withdraw burdensome treatments. Moreover, because these discussions have not been widely held with the public, the use of advance care planning to fully ensure that patients' rights will be respected should they become incompetent, has not been fully implemented.

In short, there is an enormous need for both professional and public education to ensure that patients fully understand their options for care at the end of life.

Summary

Pain is one of the compelling factors that lead patients to request physician assisted suicide and euthanasia. Uncontrolled symptoms, psychological distress and existential suffering appear to be equally profound elements in patient suffering. Lack of physician and patient knowledge, as well

as a strong dissonance in beliefs and behaviors. impact on the broad, aggressive application of pain treatment, symptom control and palliative care to the care of the dying.

There is a significant confusion between compassion and competence. Suffering is defined as unrelievable, and physician assisted suicide and euthanasia are considered the only compassionate response.

The public sees physician assisted suicide and euthanasia as the only option, emphasizing the concepts of patient autonomy and physician beneficence. The professional debate is evolving, with greater focus on the complexity of the issues. There is a strong consensus that physicians remain inadequately trained to care for the dying, and deterred economically from providing humane, compassionate care to this group of patients.

Our institutionalization of death has further exacerbated and exalted the role of physicians in regulating death.

Improved patient/physician communication, respect for patient-centered care, better physician judgement to withdraw or withhold care, and familiarity with the principles and practice of palliative care would definitely reduce the need to legalize physician assisted suicide and euthanasia.

We need broad public discussions to address what Americans' value, to address what kind of a society we are, and how we care for our dying, and to address the complex issues.

The simple attempt to solve these problems with a yes/no vote on physician assisted suicide is to attempt to solve a very complex issue with a simplistic technical approach.

We must focus our efforts and attention on improving the care of the dying. The currently proposed laws only provide for protection of physicians. They do little to advance the care of patients at the end of life. They provide a false sense of autonomy. Real autonomy at the end of life can only be realized when a full range of treatment is available and affordable and patients understand all their options.

The practical dangers inherent in legalizing physician assisted suicide need to be weighed against the potential benefits. It will conceivably be easier for a doctor to prescribed lethal medication than to care for a dying patient, especially when the patient is without family or friends, or comes from socially disadvantaged groups.

Recommendations

It is critical that the United States Government assures its citizens of quality of life at the end of life, and to this end, the government should support broad programs in palliative care, as recommended by the World Health Organization. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is

achievement of the best possible quality of life for patients and their families. Many aspects of palliative care are also applicable early in the course of illness; and in conjunction with other medical treatments. Palliative care--affirms life, and regards dying as a normal process; neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient's illness and their own bereavement. Programs of palliative care stress that illness should not be regarded as an isolated aberration in physiology, but be considered in terms of the suffering it causes and the impact that it has on the patient's family. The unit of care is the family, rather than the patient alone. Palliative care requires a team approach which recognizes that all health care workers have roles to play.

The federal government should fully assess the barriers to effective care of patients who are dying. Efforts should be made to understand the problem and its complexity before supporting a constitutional right. As Robert Burt, Professor of Law at the Yale Law School argued, "It would be ironic that at a time when Congress has just refused to guarantee health care for everyone, the judiciary selected physician assisted suicide as the one health care right that deserves constitutional status."

We need broad public discussions of the impact of such laws on physician-patient trust, on the role of a society to kill the sufferer. The competing interests and goods need to be articulated. In the current climate of a rapidly changing health care reimbursement system, and without universal access to care, such laws, if implemented, place the dying who are most vulnerable citizens at risk of death as the cheaper, easier way to limit excessive health care costs.

References

- Allenbeck P, Bolund C, Ringback G: Increased suicide rate in cancer patients. *J Clin Epidemiol* 42:611-616, 1989
- Angell M: Euthanasia. *N Engl J Med* 319:1348-1350, 1992
- Annas GJ: The health care proxy and the living will. *N Engl J Med* 324:1210-1213, 1991
- Anonymous: It's Over Debbie. *JAMA* 259:272, 1988
- Ashby M, Wakefield M: Attitudes to some aspects of death and dying, living wills and substituted health care decision making in South Australia. *Palliative Med* 7:273-282, 1993
- Ashley BM, O'Rourke KD: Healthcare ethics and theological analysis. Catholic Health Association, St. Louis, 1989
- Back AL, Wallace JJ, Starks HE, Pearlman RA: Physician-assisted suicide and euthanasia in Washington State. *JAMA* 275:919-925, 1996.
- Barracough BM: Suicide in the elderly. *Br J Psychiatry Suppl* 6:87-97, 1971
- Belkin L: There's no such thing as a simple suicide. *The New York Times*. Nov. 14, 1993, pp. 50-55.
- Benrubi GI: Euthanasia - the need for procedural safeguards. *N Engl J Med* 326:197-198, 1992
- Block SD, Billings JA: Patient requests to hasten death: evaluation and management of terminal care. *Arch Intern Med* 154:2039-2047, 1994.
- Block SD, Billings JA: Patient requests for euthanasia and assisted suicide in terminal illness. The role of the psychiatrist. *Psychosomatics* 36:445-457, 1995.
- Bolund C: Suicide and cancer: II. Medical and care factors in suicide by cancer patients in Sweden: 1973-1976. *J Psychosoc Oncol* 3:17-30, 1985
- Breitbart W. Suicide in cancer patients. *Oncology* 1:49-55, 1987.
- Breitbart W. Cancer pain and suicide. pp. 399-412. In Foley KM, Bonica JJ, Ventafridda V, (eds): *Advances in Pain Research and Therapy*, Vol. 16, Raven Press, New York, 1990
- Breitbart W, Passik S, Bronaugh T, et al: Pain in the ambulatory AIDS patient: prevalence

and psychosocial correlates (abstract). 38th Annual Meeting, Academy of Psychosomatic Medicine, October 17-20, 1991, Atlanta, GA

Breitbart W, Passik SD, Eller K, Sison A: Suicidal ideation in AIDS: the roles of pain and mood. (abstract) 145th Annual Meeting, American Psychiatric Association, May 2-7, 1992, Washington, D.C. 1992 New Research Program and Abstracts, p. 113

Breitbart W, Rosenfeld BD, Passik SD: Interest in physician-assisted suicide among ambulatory HIV-infected patients. *Am J Psychiatry* 153:238-242, 1996.

Breitbart W, Marotta R, Platta MM, Weisman H, Derevenco M, Grau C, Corbera K, Raymond S, Lund S, Jacobsen P: A double-blind trial of haloperidol, chlorpromazine, and lorazepam in the treatment of delirium in hospitalized AIDS patients. *Am J Psychiatry* 153:231-237, 1996.

Brody, H: Assisted Death - A compassionate response to a medical failure. *N Engl J Med* 327:1384-1388, 1992

Brown JH, Henteleff P, Barakat S, Rowe CJ: Is it normal for terminally ill patients to desire death. *Am J Psychiatry* 143:208-211, 1986

Bukberg J, Penman D, Holland J: Depression in hospitalized cancer patients. *Psychosom Med* 43:199-212, 1984

Burt RA: Death made too easy. *The New York Times*, November 16, 1994.

Byock I: The euthanasia/assisted suicide debate matures. *Amer J Hospice and Palliative Care*, March/April, 1993

Callahan D: When self-determination runs amok. *Hastings Center Report* Mar-Apr: 52-55, 1992

Callahan D: *The Troubled Dream of Life*. Simon and Schuster, New York, 1993.

Caralis PV, Hammond JS: Attitudes of medical students, housestaff, and faculty physicians toward euthanasia and termination of lifesustaining treatment. *Critical Care Medicine* 20:683-690, 1992

Carson, R: Washington's I-119. *Hastings Center Report* Mar-Apr:7-9, 1992

Cassel CK, Meier DE: Morals and moralism in the debates on euthanasia and assisted suicide. *N Engl J Med* 323:750-752, 1990

Cassell E: The nature of suffering and the goals of medicine. *N Engl J Med* 306:639-645, 1982

Cassell EJ: Recognizing suffering. *Hastings Center Report* May-June:24-31, 1991

Center for Health Ethics and Policy, University of Colorado Withholding and Withdrawing Life-Sustaining Treatment: A survey of opinions and experiences of Colorado physicians. Graduate School of Public Affairs, Denver, Colorado, May, 1988

Chapman Cr, Gavrin J: Suffering and its relationship to pain. *J Palliative Care* 9:2:5-113, 1993

Charnow JA: Most internists support patients' "Right to Die." surveys find. *ACP Observer*. June 8, 1991

Cherny NI, Coyle NM, Foley KM: Definition and taxonomy of suffering in advanced cancer.

Cherny NI, Portenoy RK: Cancer pain management. *Cancer* 72:3393-3415, 1993

Cherny NI, Coyle NM, Foley KM: Suffering in the advanced cancer patient. Part I: A definition and taxonomy. *Journal of Palliative Care*, 10(2):57-70, 1994.

Cherny NI, Coyle NM, Foley KM: The treatment of suffering when patients request elective death. *J Palliative Care* 10(2):71-79, 1994.

Cherny NI, Portenoy RK: Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. *J Palliative Care* 10(2):31-38, 1994.

Chochinov HM, Wilson KG: The euthanasia debate: attitudes, practices and psychiatric considerations. *Can J Psychiatry*, 40:593-602, 1995.

Chochinov HM, Wilson KG, Enns M, Mowchun N, Lander S, Levitt M, Clinch JJ: Desire for death in the terminally ill. *Am J Psychiatry* 152:1185-1191, 1995.

Cleeland CS, Cleeland LM, Dar R, Rinehardt LC: Factors influencing physician management of cancer pain. *Cancer* 58:796-800, 1986.

Cleeland CS, Gonin R, Hatfield AK, et al. Pain and its treatment in outpatients with metastatic cancer. *N Engl J Med* 330:592-596, 1994

Coene RD: Hospice-zorg nader bekeken. *Med Contact* 39:1156-1158, 1991

Connors AF, Dawson NV, Desbiens NA, et al: A controlled trial to improve care for

seriously ill hospitalized patients. JAMA 274:1591-1598, 1995.

Conwell Y, Caine, ED: Rational suicide and the right to die. Reality and Myth. N Engl J Med 325:1100-1102, 1991

Council on Ethical and Judicial Affairs, American Medical Association: Decisions near the end of life. JAMA 267:2229-2233, 1992

Coyle N: The euthanasia and physician-assisted suicide debate: issues for nursing. Oncol Nurs Forum 19:41-46, 1992.

Coyle N, Adelhardt J, Foley KM, Portenoy RK: Character of terminal illness in the advanced cancer patient: pain and other symptoms during the last four weeks of life. J Pain Symptom Manage 5:83-93, 1990.

Crosby C: Internists grapple with how they should respond to requests for aid in dying. The Internist 33:10, 1992

Derogatis LR, Marrow GR, Fetting J, et al: The prevalence of psychiatric disorders among cancer patients. JAMA 249:751-757, 1983

Devons CAJ, Mulvihill M: Physician attitudes about physician-assisted death. The Gerontologist 32:70, 1992

de Wachter MAM: Active euthanasia in the Netherlands. JAMA 262:3316-3319, 1989.

Dorrepaal KL, Aaronson NK, Van Dam F: Pain experience and pain management among hospitalized cancer patients. Cancer 63:593-598, 1989

Doukas DJ, Waterhouse D, Gorenflo DW, Seid J: Attitudes and behaviors on physician-assisted death: a study of Michigan oncologists. J Clin Oncology 13:1055-1061, 1995.

Doyle D, Hanks G, MacDonald N: The Oxford Textbook of Palliative Care. Oxford University Press, New York, 1993

Dorrepaal KL: Pijn Bijpatienten met Kanker. University of Amsterdam, Amsterdam 1989.

Emanuel EJ: Euthanasia and cancer: historical, ethical and moral perspectives. Where In press, 1994

Emanuel EJ: A review of the ethical and legal aspects of terminating medical care. American Journal of Medicine 84:291-301, 1988

Emmanuel L, Barry MJ, Sloeckle JD: Advance directives for medical care. a case for greater use. *New Engl J Med* 324:889-895, 1991

Fisher McD, Raper RF: Withdrawing and withholding treatment in intensive care. *The Medical Journal of Australia* 153:217-229, 1990

Foley KM: The treatment of cancer pain. *N Engl J Med* 313:84-95, 1985

Foley KM: The relationship of pain and symptom management to patient requests for physician-assisted suicide. *J Pain Symptom Manage* 6:289-297, 1991.

Foley KM: Book review of *Death and Dignity*. *Hastings Center Report*, May-June, 45-46.

Foley KM: Management of cancer pain. pp. 2417-2228. In Devita VT, Hellman SA, Rosenberg SJ (eds): *Cancer Principles & Practice of Oncology*. 4th ed. J. Lippincott, New York, 1993

Foley KM: For more rhetoric and less regulation. A rebuttal. *Pain Forum* 4:197-198, 1995.

Foley KM: Pain, physician assisted suicide and euthanasia. *Pain Forum* 4: 163-178, 1995.

Gaylin WL, Kass R, Pellegrino ED, Siegler M: Doctors must not kill. *JAMA* 259:2139-2140, 1988

Gomez CF. *Regulating Death: Euthanasia and the Case of the Netherlands*. Free Press, New York, 1991

Helig S: The San Francisco Medical Society Euthanasia Survey: Results and Analysis. *San Francisco Medicine* 61:24-34, 1988

Hendin H: Seduced by death: doctors, patients and the Dutch cure. *Issues Law Med* 10:123-168, 1994.

Hill TP: The right to die: legal and ethical considerations. *Southern Medical Journal* 85:(Supplement 2):55-59, 1992

Hill, TP: *Freedom from pain: a matter of rights? Choice in Dying*, New York,

Hill TP: Treating the dying patient. The challenge for medical education. *Arch Int Med* 155:1265-1269, 1995.

Hiller RJ: Ethics and hospice physicians. *Am J Hospice Palliative Care*, Jan/Feb, 17-26, 1991

Holland J, Rowland JH (eds): Handbook of Psychooncology, Psychological Care of the Patient with Cancer. Oxford Press, New York, 1989

Humphrey D. Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying. Eugene, OR, the Hemlock Society, 1991.

Ingham J, Foley KM: Epidemiology of death. Submitted for publication, 1996.

Ingham J, Foley KM: Pain and the barriers to its relief at the end of life: a lesson for improving end of life health care. Submitted for publication, 1996.

It's Over, Debbie (letters to the editor): JAMA 259:2094-2098, 1988

Joranson DE: Medical board guidelines for intractable pain treatment. APS Bulletin 5(3), 1995.

Kane RL, Bernstein L, Wales J, Rothenberg R: Hospice effectiveness in controlling pain. JAMA 253:2683-2686, 1985

Keown J: On regulating death. Hastings Center Report Mar-Apr:39-43, 1992

Knox RA: Poll: Americans favor mercy killing. Boston Globe November 3, 1991:1,22.

Kovacs M, Beck AT, Weissman A: Hopelessness: an indication of suicidal risk. Suicide 5:98-103, 1975

Kubler-Ross E: On Death and Dying. Macmillan Publishing Co Inc, New York, 1969

Lebovits AK, Lefkowitz M, McCarthy D, et al: The prevalence and management of pain in patients with AIDS. A review of 134 cases. Clin J Pain 5:245-248, 1989

Ma R, Fade AE: Assisted suicide laws reviewed. Choice in Dying News 2:4, 1993

MacKenzie TB, Popkin MK: Suicide in the medical patient. Int J Psychiatry Med. 17:3-22, 1987

Marzuk PM, Tierney H, Tardiff K, et al: Increased risk of suicide in persons with AIDS. JAMA 259:1333-1337, 1988

Marzuk PM, Tardiff K, Hirsch et al: Increase in suicide by asphyxiation in New York City after the publication of Final Exit. NEJM 329:1508-1510, 1993

Meier DE, Cassel CK: Euthanasia in old age: a case study and ethical analysis. J Am

Geriatr Soc. 31:294-298, 1983

Meier DE: Doctor attitudes and experiences with physician-assisted death. Review of the literature. In: Physician Assisted Death, Humber JM, Almeder RS, Kastings GA (eds). Humana Press, New Jersey, pp. 5-24, 1993

Merriman AC, Gunn DB, Dickinson GE: Learning to care for the dying. Acad Med 65:35-36, 1991.

Misbin RI: Sounding Board - Physicians' aid in dying. N Engl Med 325:1307-1311, 1991

Moffic HS, Paykel ES: Depression in medical in-patients. Br J Psychiatry 126:346-53, 1975

Mount B: A final crescendo of pain. Palliative Care 6:3-4, 1991

National Center for Health Statistics: Health statistics on older persons: United States, 1986. Vital and health statistics. Series 3, No. 25, Washington, D.C.: Government Printing Office, 1987. (DHHS publication no. (PHS) 87-1409.)

National Opinion Poll Market Research: Attitudes toward euthanasia among Britain's General Practitioner's. NOP Market Research Ltd., London, 1987

New York Times: Kevorkian placed under arrest. Nov. 7, 1993

Nielsen AC III, Williams TA: Depression in ambulatory medical patients: prevalence by self-report questionnaire and recognition by nonpsychiatric physicians. Arch Gen Psychiatry 37:999-1004, 1980

Novack DH: Therapeutic aspects of the clinical encounter. J Gen Intern Med. 2:346-355, 1987

Okimoto JT, Barnes RF, Veith RC, Raskin MA, Inui TS, Carter WB: Screening for depression in geriatric medical patients. Am J Psychiatry 139:799-802, 1982

Orentlicher D: Physician participation in assisted suicide. JAMA 262:1844-1845, 1989

Overmyer M: National survey: physicians' views on the right to die. Physician's Management. 1991;31:40-60.

Owen C, Tennant C, Levi J, Jones M: Suicide & euthanasia: patient attitudes in the control of cancer. Psychooncology 1:79-88, 1992.

Pollard B, Winton R: Why doctors and nurses must not kill patients. Med J Aust 158:426-

429, 1993.

Portenoy RK, Coyle N, Kash K, et al: Determinants of the willingness to endorse assisted suicide: a survey of physicians, nurses and social workers. Manuscript in preparation, 1994

Portenoy RK: Pain and quality of life: clinical issues and implications for research. *Oncology* 4:172-178, 1990

President' s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Deciding to forego life-sustaining treatment. U.S. Government Printing Office, Washington D.C., 1983

Quill TE, Cassel CK, Meier DE: Care of the hopelessly ill: proposed clinical criteria for physician-assisted suicide. *N Engl J Med* 327:1280-1384, 1992

Quill TE: Doctor, I want to die. Will you help me? *JAMA* 270:870-875, 1993

Quill T: *Death & Dignity: Making Choices and Taking Charge*. W.W. Norton & Co., New York, 1993

Quill T: Death and dignity -- a case of individualized decision making. *N Engl J Med* 324:691-694, 1991

Reidinger P: Law poll. *ABA Journal*, June:20, 1988

Reiser SJ: The era of the patient. *JAMA* 269:1012-1017, 1993.

Rhymes J: Hospice care in America. *JAMA* 264:369372, 1990

Richman J: A rational approach to rational suicide. *Suicide Life Threat Behav.* 22:130-141, 1992

Rollins B: *Last Wish*. New York: Simon & Schuster, 1984

Roy D: When the dying demand death. *J Palliative Care* 9, 4:3-4, 1994

Roy D: Need they sleep before they die? *J Palliative Care* 6:3-4, 1991

Roy D: Biology and meaning in suffering. *J Palliative Care* 9:2:3-4, 1993

Rundell JR, Kyle KM, Brown GR, Thomason JL: Risk factors for suicide attempts in a human immunodeficiency virus screening program. *Psychosomatics* 33:24-27, 1992

Saunders C: The management of terminal illness. London: Edward Arnold, 1967.

Schofferman J, Brody R: Pain in far advanced AIDS. pp. 379-38. In Foley KM, Bonica JJ, Ventafridda V (eds). *Advances in Pain Research and Therapy*, Vol. 16. New York: Raven Press, 1990

Siegel K, Tuckel P: Rational suicide and the terminally ill cancer patient. *Omega* 15:263-269, 1984

Siegel E: Rational suicide: considerations for the clinician. *Psychiatr Q* 54:77-83, 1982

Singer PA, Siegler M: Euthanasia: a critique. *N Engl J Med* 322:1881-1883, 1990

Society of Critical Care Medicine Ethics Committee: Attitudes of critical care medicine professionals concerning forgoing life-sustaining treatments. *Critical Care Medicine* 20:320-326, 1992

Solomon M, O'Donnell L, Jennings B, et al: Decisions near the end of life. Professional views of life-sustaining treatments. *Amer J Pub Heal* 83:14-21, 1993

Somerville M: The song of death: the lyrics of euthanasia. *J Health Policy* 90:1-75, 1993

Steinmetz G, Wright M, Gabel LL, Williams T: Family physicians' involvement with dying patients and their families. *Arch Fam Med* 2:753-761, 1995/

Terry D: While out on bail Kevorkian attends a doctor's suicide. *The New York Times*, Nov. 23, 1993, p. 1

The Hastings Center: Guidelines on the termination of life-sustaining treatment and the care of the dying. (Bloomington, Ind.: Indiana University Press 1987).

The Hemlock Society: 1991 Roper Poll of the West Coast on Euthanasia, New York, Roper Organization, May 1991.

The Hemlock Society: 1987 Survey of California Physicians Regarding Voluntary Active Euthanasia for the Terminally Ill, The National Hemlock Society, Feb. 1987.

The New York Times: Kevorkian placed under arrest, Nov. 7, 1993.

The New York Times: Police wonder at silence in suicide for hire. Dec. 12, 1993, p 44

The Rummelink Report: Health Policy. (Special Issue) 22:1-262, Where, by whom, 1992

- Twycross RG, Lack SA: Symptom Control in Far Advanced Cancer: Pain Relief. Pitman Books Ltd., London, 1984
- van Delden JJM, Pijnenborg L, van der Maas, PJ: The Rummelink Study: Two Years Later. Hastings Center Report 23(6):24-27, 1993
- Van Der Maas PJ, Van Delden JJM, Pijnenborg L, Looman CWN: Euthanasia and other medical decisions concerning the end of life. The Lancet 1991;338:669-674.
- Van Der Wal G: Euthanasie en hulp bij zelfdoding door huisartsen, Rotterdam, 1992.
- Van Roenn JH, Cleeland CS, Gonin R, Hatfield A, Pandya KJ. Physicians' attitudes toward cancer pain management survey: results of the Eastern Cooperative Oncology Group Survey. Ann Int Med 1993, 119, 121-126.
- Ventafredda V, Ripamonti C, DeConno F, Tamburini M, Casseleth BR: Symptom prevalence and control during cancer patients' last days of life. J Palliative Care, 6:7-11, 1990.
- Vladeck BC: Editorial: Beliefs vs. behaviors in healthcare decision making. Am J Public Health, Vol. 83, No. 1, 13-25, 1993.
- Wachter MAM: Euthanasia in the Netherlands. Hastings Center Report Mar-Apr:23-38, 1992
- Wanzer SH, Adelstein SJ, Cranford RE, et al: The physician's responsibility toward hopelessly ill patients. N Engl J Med 310:955-959, 1984
- Wanzer SH, Federman DD, Adelstein J, et al: The Physician's responsibility toward hopelessly ill patients. A second look. N Engl J Med 320:844-849, 1989
- Washington State Medical Association: Initiative 119 WSMA membership survey. (Seattle: Washington State Medical Association March 1991).
- Watts DT, Howell T, Priefer GA: Geriatricians' attitudes toward assisting suicide of dementia patients. J Am Geriatr Soc 40:878-885, 1992
- Wesley P: Dying safely. Issues Law Med 8:467-483, 1993.
- Whippen DA, Canellos GP: Burnout syndrome in the practice of oncology: results of a random survey of 1,000 oncologists. J Clin Oncol 9:255-259, 1991
- World Health Organization: Cancer Pain Relief and Palliative Care. Geneva: World Health Organization, 1989

World Health Organization: Cancer Pain Relief and Palliative Care. 2nd Edition. Geneva: World Health Organization, 1996.

Zimmerman J. Hospice: Complete care for the terminally ill. Urban & Schwarzenberg, Baltimore, 1981

Zylicz Z: Euthanasia. Lancet 338:1150, 1991

Mr. CANADY. Thank you Dr. Foley.
Dr. Quill.

STATEMENT OF TIMOTHY E. QUILL, PROFESSOR OF MEDICINE/PSYCHIATRY, UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE

Dr. QUILL. I want to thank you for inviting me, and I thought I might try to give you a different perspective on this issue, and tell you about where the passion comes from for me on this issue.

I am a primary care doctor; primarily that is my experience with patients; I work with them over the long haul. Many of my patients are fighting for life using high technology. I enjoy that fight for life, but I also know that technology, if used indiscriminately, can prolong the process of dying. We just saw with the support study, *Journal of the American Medical Association* 1995; 274:1591-98, that, unthinkingly, just prolonging life really produced tremendous suffering at the end of life.

I work with my patients to help them make good decisions when they are not going to survive, when treatment is no longer working, so they can face death and make decisions to try to address their own suffering.

Under these circumstances, I refer all of my patients to hospice programs, and we use the resources that Dr. Kathleen Foley has talked about, in a collaborative way. But I also know that a few patients, in spite of extremely profound efforts to care, begin to suffer in ways that, to you, would be perhaps unthinkable. They begin to, as Eric Casell has conceptualized, disintegrate as persons. They cannot reconstitute. The only way they see of self-preservation is in their death. These are what I would consider bad deaths, and they are profound experiences. Anybody who has witnessed this will understand.

My belief is that we have an obligation to respond to people who are dying bad deaths. We don't have simple solutions for them. I know that Dr. Foley, her programs, and other good doctors do respond, although physicians don't have a lot of guidance about how to do that right now because these decisions are all filled with moral ambiguity.

Our patients are forcing us to face this. This debate is not being driven by doctors. Patients and family members who have been a part of bad deaths, seen it in their own families and seen doctors being afraid to respond because they might be accused of assisting death, are pushing this issue.

The safest course, from a legal point of view right now, is for physicians to walk away from those kinds of problems. We see too many doctors doing that.

The values of hospice care should drive this entire debate. They are somewhat different from the values of acute medical care. In acute medical care, we are going to treat the disease. We often ask people to endure considerable suffering in the interest of prolonging their lives, including chemotherapy, trips to intensive care units, and hospice care. In hospice care we accept the fact we can no longer treat the disease in ways that would be effective, so we are going to treat the person's suffering. That is going to be our foremost objective, and we may even use measures to treat that suffer-

ing that indirectly contribute to a person's death. This has liberated us in some ways to use adequate pain medicine and to reassure people that we will not be afraid at the end to use sufficient medicine of their pain is severe.

We also, within hospice care, individualize care as much as possible. It is intensive care of the person. That means finding out who that unique individual is, what they still need to accomplish, and what is important to them in the last phase of their life. We need to try to help people find their own path. They would all choose to get better if that was in their purview, but it is not.

Perhaps the most fundamental obligation of hospice care is non-abandonment. That means we are going to go through that process together no matter where it goes. If it takes us to places where hospice care tells us exactly what to do, we will go through that together. But if it takes you down a dark alley where nobody knows what to do when the landmarks aren't there and it is completely unclear, we are also going to go through that together and solve the problems that need to be solved.

Now I agree with Dr. Foley about the inadequacies of hospice care in many areas of the country right now—access and pain relief. But I also know that there are many, many doctors in hospice, primary care, oncology, AIDS and geriatrics who are doing a spectacular job caring for their dying patients and making this kind of commitment.

If we are going to allow physician-assisted death, it should be a very narrow question. It is only for those patients with access to good care, who are getting all-out efforts to relieve their suffering, who then continue to suffer in a severe way. It is a very limited question. If we can keep it narrow, therein may lie the safety. If we can't do that, it becomes a more dangerous question. Patients who request a physician-assisted death have often struggled a long time against their disease and made the transition to hospice, then struggled a long time to keep going in hospice; they have not taken a short road.

What we do for these people at last resort also says a lot about us as a culture. If we walk away from them because it is too dangerous, that too is abandonment. We have to be much more creative about how we are going to respond to them. I hope we agree that there needs to be some kind of response.

We know that many doctors do respond right now by helping their patients to die. Recently, the first epidemiological study about current U.S. practices in Washington State was published, JAMA 1996; 275:919–925, 16 percent of doctors reported having a genuine request from a dying patient for an assisted death in a 1-year study period. A quarter of those doctors adhered to that request and provided lethal medication. They did so without consultation because it is currently legally dangerous to get such a consultation in this situation. I would submit that such secret processes are much worse for patients and doctors than a more open process.

I want to tell you one clinical story to let you know just how serious this process is. You may disagree about the policy issues, but I want you to understand what patients and families are dealing with.

This story was told to me by a patient of mine. It is about a man named Bill, a retired a lawyer, who was enjoying his retirement. He developed macular degeneration and lost his ability to see. He still found a way to keep going, and then developed oral cancer. He still wanted to fight his disease. He went through surgery, chemotherapy and radiation. He had a complication of his radiation in which he lost his hearing; i.e., now he couldn't see and hear. He was also somewhat deformed by the surgery, but still was able to keep going.

When his cancer recurred, he was appropriately referred to a hospice program. His life was a fraction of what it used to be. He was just barely finding life tolerable when his cancer recurred in his nose. There was no pain involved, but he had copious secretions; so copious he had to wear a sanitary napkin under his nose, and change it every hour.

This took Bill over the line. He couldn't find meaning in living this way, and he started talking to people about wanting to die, and wanting some help. He found out people were afraid to talk with him about this, because doctors aren't supposed to be involved in these processes. Dr. Foley and I both agree, even if we feel we can't assist somebody to die, we have to learn to talk with patients who want to die. They are alone with these feelings without us talking to them.

My patient was a hospice nurse and member of the Hemlock Society. Bill was so relieved that somebody would actually talk with him about this. They decided he probably had enough medicine on hand to take an overdose and made elaborate plans, as people do in those circumstances, without any medical intervention or support.

On the day this was supposed to occur, Bill said that he couldn't do it. He didn't want to put his family through the legal jeopardy. They said they were willing to take the risk, but that it was up to him. They had some coffee. Bill then excused himself, went out in the back room, and shot himself in the head. Only he didn't die. He was whisked to the emergency room, where they tried to save his life. After about 4 hours of work, the doctors decided they couldn't save it. They offered to give him some morphine to keep him comfortable.

Bill would clearly have been helped by a more open system. There has to be a better way. These kinds of stories are what is driving this public debate in the public. People will be afraid—we will be afraid to address this issue.

I can tell you a lot of good stories about good deaths. That is the majority of the experience on hospice. But these are the stories that stick in people's mind.

Let me say a few words in conclusion. Rules and laws, as they are currently constituted, are making doctors reluctant to make the kind of commitments we want them to make. They reinforce secrecy, ambiguity, unclear thinking, and a tendency to pull back when the going gets tough.

We have two interlocking public policy challenges: One, as Dr. Foley said, to improve access and delivery of hospice care for everybody who is dying. It is the standard of care against which every-

thing else should be measured. But we also have an obligation to respond to those few remaining bad deaths as medical emergencies.

Safeguards should be instituted to regulate this kind of practice. The safeguard would require that hospice care be available and tried before a physician-assisted death would be a possibility. It would only be used as a last resort for terminally ill patients whose suffering could not be relieved by adequate palliative measures. It would be required that a palliative specialist like Dr. Foley would see such a patient to make sure that all stones had been turned. Documentation and open accountability would also be required.

Our commitment not to abandon patients is fundamental in this process. When people are struggling for life in the ICU, we show no restraint in our efforts to keep their life going. When a person is disintegrating prior to death, what it means to be a person is at stake. We must show similar creativity and lack of restraint. It is nothing short of a medical emergency.

Our public policy must reinforce commitment to hospice care, guaranteeing access. It must make abandonment, walking away from these problems, the worse possible outcome, and it must create an open, accessible, predictable system for patients and families to count on if they are unfortunate enough to fail to respond to hospice care.

[The prepared statement of Dr. Quill follows:]

PREPARED STATEMENT OF TIMOTHY E. QUILL, M.D., PROFESSOR OF MEDICINE/
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The Second Circuit Federal Court unanimously decided that laws arbitrarily prohibiting physician-assisted suicide violate the equal protection clause of the Constitution, thereby reinforcing a similar decision reached last month by the Ninth Circuit. Viewed narrowly, these decisions will allow suffering, terminally ill patients to openly work with their doctors if they want an assisted death. State legislatures and professional groups have the duty to ensure such processes are carried out responsibly, but they cannot make access to a physician-assisted death so restricted and difficult that patients have to beg for assistance, or act on their own in despair. In making their decisions, both courts took seriously the heart-rending dilemmas faced by dying patients who have no good choices, and see death as their only escape.

This decision is a victory for terminally ill patients, but only if other elements of a humane health care system are intact and operational. The decision to seek death should be viewed as a cry for help, the meaning of which can only be determined through careful listening and exploration. Such requests could be the result of undertreated pain or unrecognized depression that might be relieved with good palliative treatment. But these requests might also reflect fully considered, rational wishes to die, in which case the physician's obligations are more complex. Such clinical assessments can be difficult, but are ideally carried out using the collaborative expertise of primary care physicians, and specialists in palliative care and psychiatry.

In the past, if physicians assisted their patients to die by providing lethal prescriptions, they risked prosecution if it was discovered. A recent Washington state survey showed that 16 percent of physicians had received a genuine request for a physician-assisted death within a one year study period, and one

quarter of those physicians responded by providing a potentially lethal prescription. Most acted completely in secret, without benefit of consultation. To stay within the law, these physicians would have had to refuse the request even if they agreed that the patient had no other acceptable options, thereby abandoning the patient to act on his own or to continue suffering. Now such processes can potentially be conducted out in the open, collaboratively rather than secretly, subject to carefully constructed safeguards that patients can count on.

But before we uncritically accept the prospect of legally allowing physician-assisted death, we must use this opportunity to ensure that terminally ill patients have full access to hospice care. Hospice care is a highly effective alternative to a "high technology" death in the hospital that many fear. The primary purpose of hospice programs is to enhance the quality of life for the time that remains. Resources from a multidisciplinary team address the physical, social, psychological and spiritual dimensions of the patient's suffering. Hospice care costs less and is of higher quality than acute care for the terminally ill, and it is highly effective. It is the standard of care for the dying, against which all other interventions should be measured.

Assisted suicide should never be an alternative to good palliative care. Physician-assisted death should be restricted to those relatively few patients for whom hospice care ceases to be effective, and suffering is so intolerable that death is their only answer. The Second Circuit Court decision acknowledges the devastation experienced by these patients, and considers it a medical emergency which cannot be ignored simply because the public policy challenges are difficult. The patient's personhood is at stake. Our obligation as physicians, lawyers, policy makers, and as human beings requires that we be as responsive as possible. The interlocked public policy questions include: 1) How can we improve access to good palliative care so that it is available to all terminally ill patients in a timely way? and 2) How should we respond to those infrequent, but troubling patients who still suffer intolerably and want to die in spite of our best efforts?

These court decisions should move the public debate beyond the divisive rhetoric toward consensus

building among those with a common interest in improving the care of the dying. It is self-deceptive and demeaning to suggest that all requests for physician-assisted death result from inadequate caring by medical professionals, or from psychopathology or spiritual weakness by patients. Ironically, the chances of having to face these daunting questions may be increased in part because of our successes helping severely ill patients to live longer with the aide of our vast medical armamentarium. The polarizing discourse and the legal uncertainty in the past have made many physicians even more reluctant than they already were to work closely with their incurably ill and dying patients.

Physicians are already openly involved in some processes that ease death. Patients can stop any life-sustaining treatment, including dialysis, respirators, medicines and fluids, even if it will result in their wished for death. Rapidly increasing doses of opioids can be used to relieve terminal pain, even in amounts that indirectly contribute to a patient's death. (This promise can be very reassuring to a patient who has witnessed a painful death where opioids have been withheld out of ill conceived fears of addiction or of contributing to death.) The primary intent of each of these interventions is to relieve suffering, yet they frequently contribute to the patient's sought after death. Both Circuit Courts have determined that allowing some patients to die simply because they have a life-sustaining treatment to stop or because they have pain that can be aggressively treated discriminates against those who may be suffering more egregiously, but have no such interventions available because of arbitrary elements of their illness. There is a slowly growing consensus within medicine, law and ethics that any treatment that ends life should only be used as a last resort.

The safeguards proposed by several groups for any physician-assisted death are remarkably similar: 1) The request must come from the patient, who must be mentally competent and fully informed about the alternatives. 2) The patient must be terminally ill, and suffering intolerably in ways that cannot be adequately relieved by palliative measures. 3) An independent second opinion with expertise in palliative medicine must verify that the patient meets agreed upon criteria. A psychiatrist should evaluate the patient if there are questions about mental capacity. 4) Explicit processes of documentation, reporting, and review

should be in place so the practice can be better understood, improved over time, and monitored. The courts have now challenged the states and professionals under their jurisdiction to operationalize such safeguards into a system that is responsive to and protective of terminally ill patients.

In the current unstable medical and legal climates, we must teach doctors and reassure patients that the medical profession will fulfill its obligation to maintain continuity of care using skilled palliative methods with their dying patients, and respond to the few remaining bad deaths as medical emergencies. For health care professionals to be more responsive, we will need to be clear about the ethical and legal acceptability of stopping life-sustaining therapy, using high doses of opioid pain relievers, as well as physician-assisted death as a last resort. Instead of pretending that we do not currently ease death, we must now work together to develop clinical, ethical, and legal guidelines, and then carefully research whether they are acceptable to patients and effective at preventing abuse. All available options to alleviate suffering must be publicized to both physicians and patients, for we have an obligation to be responsive to those who are disintegrating as persons in spite of our best efforts without violating their or our personal values. The method used to help patients at the very end is less important than more fundamental processes of caring, joint decision making, excellent palliative care, and a commitment not to abandon no matter how the process unfolds. The recent Circuit Court decisions reinforce this commitment, and bring it out in the open instead of behind closed doors.

APPENDED REFERENCES

1. Quill TE, Cassel C, Meier D. Care of the Hopelessly Ill: Potential Criteria for Physician-Assisted Suicide. *New England Journal of Medicine*. 1992;327:1380-84.
2. Baron CH, Bergstresser C, Brock DW, Cole GF, Dorfman NS, Johnson JA, Schnipper LE, Vorenberg J, Wanzer SH. A Model State Act to Authorize and Regulate Physician-Assisted Suicide. *Harvard Journal on Legislation*. 1996;33(1):1-34.
3. Quill TE, Brody RV. You Promised Me I Wouldn't Die Like This! A Bad Death as a Medical Emergency. *Archives of Internal Medicine*. 1995;155:1250-54.

SOUNDING BOARD

CARE OF THE HOPELESSLY ILL

Proposed Clinical Criteria for Physician-Assisted Suicide

ONE of medicine's most important purposes is to allow hopelessly ill persons to die with as much comfort, control, and dignity as possible. The philosophy and techniques of comfort care provide a humane alternative to more traditional, curative medical approaches in helping patients achieve this end.¹⁻⁶ Yet there remain instances in which incurably ill patients suffer intolerably before death despite comprehensive efforts to provide comfort. Some of these patients would rather die than continue to live under the conditions imposed by their illness, and a few request assistance from their physicians.

The patients who ask us to face such predicaments do not fall into simple diagnostic categories. Until recently, their problems have been relatively unacknowledged and unexplored by the medical profession, so little is objectively known about the spectrum and prevalence of such requests or about the range of physicians' responses.⁷⁻¹⁰ Yet each request can be compelling. Consider the following patients: a former athlete, weighing 80 lb (36 kg) after an eight-year struggle with the acquired immunodeficiency syndrome (AIDS), who is losing his sight and his memory and is terrified of AIDS dementia; a mother of seven children, continually exhausted and bed-bound at home with a gaping, foul-smelling, open wound in her abdomen, who can no longer eat and who no longer wants to fight ovarian cancer; a fiercely independent retired factory worker, quadriplegic from amyotrophic

lateral sclerosis, who no longer wants to linger in a helpless, dependent state waiting and hoping for death; a writer with extensive bone metastases from lung cancer that has not responded to chemotherapy or radiation, who cannot accept the daily choice he must make between sedation and severe pain; and a physician colleague, dying of respiratory failure from progressive pulmonary fibrosis, who does not want to be maintained on a ventilator but is equally terrified of suffocation. Like the story of "Diane," which has been told in more detail,¹¹ there are personal stories of courage and grief for each of these patients that force us to take very seriously their requests for a physician's assistance in dying.

Our purpose is to propose clinical criteria that would allow physicians to respond to requests for assisted suicide from their competent, incurably ill patients. We support the legalization of such suicide, but not of active euthanasia. We believe this position permits the best balance between a humane response to the requests of patients like those described above and the need to protect other vulnerable people. We strongly advocate intensive, unrestrained care intended to provide comfort for all incurably ill persons.¹⁻⁶ When properly applied, such comfort care should result in a tolerable death, with symptoms relatively well controlled, for most patients. Physician-assisted suicide should never be contemplated as a substitute for comprehensive comfort care or for working with patients to resolve the physical, personal, and social challenges posed by the process of dying.¹² Yet it is not idiosyncratic, selfish, or indicative of a psychiatric disorder for people with an incurable illness to want some control over how they die. The idea of a noble, dignified death, with a meaning that is deeply personal and unique, is exalted in great literature, poetry, art, and music.¹³ When an incurably ill patient asks for help in achieving such a death, we believe physicians have an obligation to explore the request fully and, under specified circumstances,

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carefully to consider making an exception to the prohibition against assisting with a suicide.

PHYSICIAN-ASSISTED SUICIDE

For a physician, assisting with suicide entails making a means of suicide (such as a prescription for barbiturates) available to a patient who is otherwise physically capable of suicide and who subsequently acts on his or her own. Physician-assisted suicide is distinguished from voluntary euthanasia, in which the physician not only makes the means available but, at the patient's request, also serves as the actual agent of death. Whereas active euthanasia is illegal throughout the United States, only 36 states have laws explicitly prohibiting assisted suicide.^{14,15} In every situation in which a physician has compassionately helped a terminally ill person to commit suicide, criminal charges have been dismissed or a verdict of not guilty has been brought^{14,15} (and Gostin L: personal communication). Although the prospect of a successful prosecution may be remote, the risk of an expensive, publicized professional and legal inquiry would be prohibitive for most physicians and would certainly keep the practice covert among those who participate.

It is not known how widespread physician-assisted suicide currently is in the United States, or how frequently patients' requests are turned down by physicians. Approximately 6000 deaths per day in the United States are said to be in some way planned or indirectly assisted,¹⁶ probably through the "double effect" of pain-relieving medications that may at the same time hasten death^{1,12} or the discontinuation of or failure to start potentially life-prolonging treatments. From 3 to 37 percent of physicians responding to anonymous surveys reported secretly taking active steps to hasten a patient's death, but these survey data were flawed by low response rates and poor design.^{7,10} Every public-opinion survey taken over the past 40 years has shown support by a majority of Americans for the idea of physician-assisted death for the terminally ill.¹⁶⁻¹⁹ A referendum with loosely defined safeguards that would have legalized both voluntary euthanasia and assisted suicide was narrowly defeated in Washington State in 1991,²⁰ and more conservatively drawn initiatives are currently on the ballot in California, before the legislature in New Hampshire, and under consideration in Florida and Oregon.

A POLICY PROPOSAL

Although physician-assisted suicide and voluntary euthanasia both involve the active facilitation of a wished-for death, there are several important distinctions between them.²¹ In assisted suicide, the final act is solely the patient's, and the risk of subtle coercion from doctors, family members, institutions, or other social forces is greatly reduced.²² The balance of power between doctor and patient is more nearly equal in physician-assisted suicide than in euthanasia. The physician is counselor and witness and makes the means available, but ultimately the patient must be the one to act or not act. In voluntary euthanasia, the physician both provides the means and carries out the

final act, with greatly amplified power over the patient and an increased risk of error, coercion, or abuse.

In view of these distinctions, we conclude that legalization of physician-assisted suicide, but not of voluntary euthanasia, is the policy best able to respond to patients' needs and to protect vulnerable people. From this perspective, physician-assisted suicide forms part of the continuum of options for comfort care, beginning with the forgoing of life-sustaining therapy, including more aggressive symptom-relieving measures, and permitting physician-assisted suicide only if all other alternatives have failed and all criteria have been met. Active voluntary euthanasia is excluded from this continuum because of the risk of abuse it presents. We recognize that this exclusion is made at a cost to competent, incurably ill patients who cannot swallow or move and who therefore cannot be helped to die by assisted suicide. Such persons, who meet agreed-on criteria in other respects, must not be abandoned to their suffering; a combination of decisions to forgo life-sustaining treatments (including food and fluids) with aggressive comfort measures (such as analgesics and sedatives) could be offered, along with a commitment to search for creative alternatives. We acknowledge that this solution is less than ideal, but we also recognize that in the United States access to medical care is currently too inequitable, and many doctor-patient relationships too impersonal, for us to tolerate the risks of permitting active voluntary euthanasia. We must monitor any change in public policy in this domain to evaluate both its benefits and its burdens.

We propose the following clinical guidelines to contribute to serious discussion about physician-assisted suicide. Although we favor a reconsideration of the legal and professional prohibitions in the case of patients who meet carefully defined criteria, we do not wish to promote an easy or impersonal process.²³ If we are to consider allowing incurably ill patients more control over their deaths, it must be as an expression of our compassion and concern about their ultimate fate after all other alternatives have been exhausted. Such patients should not be held hostage to our reluctance or inability to forge policies in this difficult area.

PROPOSED CLINICAL CRITERIA FOR PHYSICIAN-ASSISTED SUICIDE

Because assisted suicide is extraordinary and irreversible treatment, the patient's primary physician must ensure that the following conditions are clearly satisfied before proceeding. First, the patient must have a condition that is incurable and associated with severe, unrelenting suffering. The patient must understand the condition, the prognosis, and the types of comfort care available as alternatives. Although most patients making this request will be near death, we acknowledge the inexactness of such prognostications^{24,26} and do not want to exclude arbitrarily persons with incurable, but not imminently terminal, progressive illnesses, such as amyotrophic lateral sclerosis or multiple sclerosis. When there is considerable

uncertainty about the patient's medical condition or prognosis, a second opinion or opinions should be sought and the uncertainty clarified as much as possible before a final decision about the patient's request is made.

Second, the physician must ensure that the patient's suffering and the request are not the result of inadequate comfort care. All reasonable comfort-oriented measures must at least have been considered, and preferably have been tried, before the means for a physician-assisted suicide are provided. Physician-assisted suicide must never be used to circumvent the struggle to provide comprehensive care or find acceptable alternatives. The physician's prospective willingness to provide assisted suicide is a legitimate and important subject to discuss if the patient raises the question, since many patients will probably find the possibility of an escape from suffering more important than the reality.

Third, the patient must clearly and repeatedly, of his or her own free will and initiative, request to die rather than continue suffering. The physician should understand thoroughly what continued life means to the patient and why death appears preferable. A physician's too-ready acceptance of a patient's request could be perceived as encouragement to commit suicide, yet it is important not to force the patient to "beg" for assistance. Understanding the patient's desire to die and being certain that the request is serious are critical steps in evaluating the patient's rationality and ensuring that all alternative means of relieving suffering have been adequately explored. Any sign of ambivalence or uncertainty on the part of the patient should abort the process, because a clear, convincing, and continuous desire for an end of suffering through death is a strict requirement to proceed. Requests for assisted suicide made in an advance directive or by a health care surrogate should not be honored.

Fourth, the physician must be sure that the patient's judgment is not distorted. The patient must be capable of understanding the decision and its implications. The presence of depression is relevant if it is distorting rational decision making and is reversible in a way that would substantially alter the situation. Expert psychiatric evaluation should be sought when the primary physician is inexperienced in the diagnosis and treatment of depression, or when there is uncertainty about the rationality of the request or the presence of a reversible mental disorder the treatment of which would substantially change the patient's perception of his or her condition.²²

Fifth, physician-assisted suicide should be carried out only in the context of a meaningful doctor-patient relationship. Ideally, the physician should have witnessed the patient's previous illness and suffering. There may not always be a preexisting relationship, but the physician must get to know the patient personally in order to understand fully the reasons for the request. The physician must understand why the patient considers death to be the best of a limited number of very unfortunate options. The primary physi-

cian must personally confirm that each of the criteria has been met. The patient should have no doubt that the physician is committed to finding alternative solutions if at any moment the patient's mind changes. Rather than create a new subspecialty focused on death,²⁸ assistance in suicide should be given by the same physician who has been struggling with the patient to provide comfort care, and who will stand by the patient and provide care until the time of death, no matter what path is taken.²³

No physician should be forced to assist a patient in suicide if it violates the physician's fundamental values, although the patient's personal physician should think seriously before turning down such a request. Should a transfer of care be necessary, the personal physician should help the patient find another, more receptive primary physician.

Sixth, consultation with another experienced physician is required to ensure that the patient's request is voluntary and rational, the diagnosis and prognosis accurate, and the exploration of comfort-oriented alternatives thorough. The consulting physician should review the supporting materials and should interview and examine the patient.

Finally, clear documentation to support each condition is required. A system must be developed for reporting, reviewing, and studying such deaths and clearly distinguishing them from other forms of suicide. The patient, the primary physician, and the consultant must each sign a consent form. A physician-assisted suicide must neither invalidate insurance policies nor lead to an investigation by the medical examiner or an unwanted autopsy. The primary physician, the medical consultant, and the family must be assured that if the conditions agreed on are satisfied in good faith, they will be free from criminal prosecution for having assisted the patient to die.

Informing family members is strongly recommended, but whom to involve and inform should be left to the discretion and control of the patient. Similarly, spiritual counseling should be offered, depending on the patient's background and beliefs. Ideally, close family members should be an integral part of the decision-making process and should understand and support the patient's decision. If there is a major dispute between the family and the patient about how to proceed, it may require the involvement of an ethics committee or even of the courts. It is to be hoped, however, that most of these painful decisions can be worked through directly by the patient, the family, and health care providers. Under no circumstances should the family's wishes and requests override those of a competent patient.

THE METHOD

In physician-assisted suicide, a lethal amount of medication is usually prescribed that the patient then ingests. Since this process has been largely covert and unstudied, little is known about which methods are the most humane and effective. If there is a change in policy, there must be an open sharing of information within the profession, and a careful analysis of effec-

tiveness. The methods selected should be reliable and should not add to the patient's suffering. We must also provide support and careful monitoring for the patients, physicians, and families affected, since the emotional and social effects are largely unknown but are undoubtedly far-reaching.

Assistance with suicide is one of the most profound and meaningful requests a patient can make of a physician. If the patient and the physician agree that there are no acceptable alternatives and that all the required conditions have been met, the lethal medication should ideally be taken in the physician's presence. Unless the patient specifically requests it, he or she should not be left alone at the time of death. In addition to the personal physician, other health care providers and family members should be encouraged to be present, as the patient wishes. It is of the utmost importance not to abandon the patient at this critical moment. The time before a controlled death can provide an opportunity for a rich and meaningful goodbye between family members, health care providers, and the patient. For this reason, we must be sure that any policies and laws enacted to allow assisted suicide do not require that the patient be left alone at the moment of death in order for the assistants to be safe from prosecution.

BALANCING RISKS AND BENEFITS

There is an intensifying debate within and outside the medical profession about the physician's appropriate role in assisting dying.^{1,21,29-42} Although most agree that there are exceptional circumstances in which death is preferable to intolerable suffering, the case against both physician-assisted suicide and voluntary euthanasia is based mainly on the implications for public policy and the potential effect on the moral integrity of the medical profession.³³⁻⁴² The "slippery slope" argument asserts that permissive policies would inevitably lead to subtle coercion of the powerless to choose death rather than become burdens to society or their families. Access to health care in the United States is extraordinarily variable, often impersonal, and subject to intense pressures for cost containment. It may be dangerous to license physicians to take life in this unstable environment. It is also suggested that comfort care, skillfully applied, could provide a tolerable and dignified death for most persons and that physicians would have less incentive to become more proficient at providing such care if the option of a quick, controlled death were too readily available. Finally, some believe that physician-assisted death, no matter how noble and pure its intentions, could destroy the identity of the medical profession and its central ethos, protecting the sanctity of life. The question before policy makers, physicians, and voters is whether criteria such as those we have outlined here safeguard patients adequately against these risks.

The risks and burdens of continuing with the current prohibitions have been less clearly articulated in the literature.^{21,29-34} The most pressing problem is the potential abandonment of competent, incurably ill pa-

tients who yearn for death despite comprehensive comfort care. These patients may be disintegrating physically and emotionally, but death is not imminent. They have often fought heroic medical battles only to find themselves in this final condition. Those who have witnessed difficult deaths in hospice programs are not reassured by the glib assertion that we can always make death tolerable, and patients fear that physicians will abandon them if their course becomes difficult or overwhelming in the face of comfort care. In fact, there is no empirical evidence that all physical suffering associated with incurable illness can be effectively relieved. In addition, the most frightening aspect of death for many is not physical pain, but the prospect of losing control and independence and of dying in an undignified, unesthetic, absurd, and existentially unacceptable condition.

Physicians who respond to requests for assisted suicide from such patients do so at substantial professional and legal peril, often acting in secret without the benefit of consultation or support from colleagues. This covert practice discourages open and honest communication among physicians, their colleagues, and their dying patients. Decisions often depend more on the physician's values and willingness to take risks than on the compelling nature of the patient's request. There may be more risk of abuse and idiosyncratic decision making with such secret practices than with a more open, carefully defined practice. Finally, terminally ill patients who do choose to take their lives often die alone so as not to place their families or care givers in legal jeopardy.¹¹

CONCLUSIONS

Given current professional and legal prohibitions, physicians find themselves in a difficult position when they receive requests for assisted suicide from suffering patients who have exhausted the usefulness of measures for comfort care. To adhere to the letter of the law, they must turn down their patients' requests even if they find them reasonable and personally acceptable. If they accede to their patients' requests, they must risk violating legal and professional standards, and therefore they act in isolation and in secret collaboration with their patients. We believe that there is more risk for vulnerable patients and for the integrity of the profession in such hidden practices, however well intended, than there would be in a more open process restricted to competent patients who met carefully defined criteria. The medical and legal professions must collaborate if we are to create public policy that fully acknowledges irreversible suffering and offers dying patients a broader range of options to explore with their physicians.

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REFERENCES

1. Wanzer SH, Adelstein SJ, Cranford RE, et al. The physician's responsibility toward hopelessly ill patients. *N Engl J Med* 1984;310:955-9.
2. Wanzer SH, Federman DD, Adelstein SJ, et al. The physician's responsibility toward hopelessly ill patients: a second look. *N Engl J Med* 1989;320:844-9.
3. Council on Ethical and Judicial Affairs. American Medical Association. Decisions near the end of life. *JAMA* 1992;267:2229-33.
4. Rhymes J. Hospice care in America. *JAMA* 1990;264:369-72.
5. Brudfield L. Evaluation of palliative care: current status and future directions. *J Palliat Care* 1988;4(3):21-8.
6. Wallston KA, Burger C, Smith RA, et al. Comparing the quality of death for hospice and non-hospice cancer patients. *Med Care* 1988;26:177-82.
7. The National Hemlock Society. 1987 Survey of California physicians regarding voluntary active euthanasia for the terminally ill. Los Angeles: Hemlock Society, February 17, 1988.
8. Center for Health Ethics and Policy. Withholding and withdrawing life-sustaining treatment: a survey of opinions and experiences of Colorado physicians. Denver: University of Colorado Graduate School of Public Affairs, May 1988.
9. Herlig S. The SFMS Euthanasia Survey: results and analyses. *San Francisco Med J* May 1988;24-6, 34.
10. Overmyer M. National survey: physicians' views on the right to die. *Physicians Manage* 1991;31(7):40-5.
11. Quill TE. Death and dignity — a case of individualized decision making. *N Engl J Med* 1991;324:691-4.
12. Meier DE, Cassel CK. Euthanasia in old age: a case study and ethical analysis. *J Am Geriatr Soc* 1983;31:294-8.
13. Arnes P. The hour of our death. New York: Vintage Books, 1982.
14. Newman SA. Euthanasia: orchestrating "the last syllable of . . . time." *Univ Pittsb Law Rev* 1991;53:153-91.
15. Glantz LH. Withholding and withdrawing treatment: the role of the criminal law. *Law Med Health Care* 1987;88;15:231-41.
16. Malcolm A. Giving death a hand: rending issue. *New York Times*, June 14, 1990:A6.
17. Gest T. Changing the rules on dying. *U.S. News & World Report* July 9, 1990:22-4.
18. The Hemlock Society. 1990 Roper poll on physician and-in-dying, allowing Nancy Cruzan to die, and physicians obeying the living will. New York: Roper Organization, April 24-25, 1990.
19. *Idem*. 1991 Roper poll of the West Coast on euthanasia. New York: Roper Organization, May 1991.
20. Misbin RI. Physicians' aid in dying. *N Engl J Med* 1991;325:1307-11.
21. Weir RF. The morality of physician-assisted suicide. *Law Med Health Care* 1992;20:116-26.
22. Glover J. Causing death and saving lives. New York: Penguin Books, 1977: 182-9.
23. Jecker NS. Giving death a hand: when the dying and the doctor stand in a special relationship. *J Am Geriatr Soc* 1991;39:831-5.
24. Poses RM, Bekes C, Copare FJ, Scott WE. The answer to "What are my chances, doctor?" depends on whom is asked: prognostic disagreement and inaccuracy for critically ill patients. *Crit Care Med* 1989;17:827-33.
25. Charlson ME. Studies of prognosis: progress and pitfalls. *J Gen Intern Med* 1987;2:359-61.
26. Schonwetter RS, Teasdale TA, Storey P, Luchi RJ. Estimation of survival time in terminal cancer patients: an impedance to hospice admissions? *Hospice J* 1990;6:65-79.
27. Conwell Y, Caine ED. Rational suicide and the right to die — reality and myth. *N Engl J Med* 1991;325:1100-3.
28. Benrubi GL. Euthanasia — the need for procedural safeguards. *N Engl J Med* 1992;326:197-9.
29. Cassel CK, Meier DE. Morals and moralism in the debate over euthanasia and assisted suicide. *N Engl J Med* 1990;323:750-2.
30. Reichel W, Dyck AJ. Euthanasia: a contemporary moral quandary. *Lancet* 1989;2:1321-3.
31. Angell M. Euthanasia. *N Engl J Med* 1988;319:1348-50.
32. Rachels J. Active and passive euthanasia. *N Engl J Med* 1975;292:78-80.
33. Lachs J. Humane treatment and the treatment of humans. *N Engl J Med* 1976;294:838-40.
34. van der Maas PJ, van Delden JJM, Pijnenborg L, et al. Euthanasia and other medical decisions concerning the end of life. *Lancet* 1991;338:669-74.
35. Singer PA, Siegler M. Euthanasia — a critique. *N Engl J Med* 1990;322:1881-3.
36. Orentlicher D. Physician participation in assisted suicide. *JAMA* 1989;262:1844-5.
37. Wolf SM. Holding the line on euthanasia. *Hastings Cent Rep* 1989;19(1): Suppl. 13-5.
38. Gavlin W, Kass LR, Pellegrino ED, Siegler M. "Doctors must not kill." *JAMA* 1988;259:2139-40.
39. Vaux KL. Debbie's dying: mercy killing and the good death. *JAMA* 1988;259:2140-1.
40. Gomez CF. Regulating death: euthanasia and the case of the Netherlands. New York: Free Press, 1991.
41. Brahmans D. Euthanasia in the Netherlands. *Lancet* 1990;335:591-2.
42. Leenen HJJ. Coma patients in The Netherlands. *BMJ* 1990;300:69.

COMMENTARY

'You Promised Me I Wouldn't Die Like This!'

A Bad Death as a Medical Emergency

DYING is a time of vulnerability and potential. Ideally, it can be a time of spiritual healing and personal connection, but it can also be dominated by physical symptoms and fear of the future. Dying patients depend on their physicians, nurses, and social workers to approach them with skill, knowledge, caring, and compassion.¹⁻³ The core commitment made by health care providers to their dying patients is nonabandonment—that no matter what happens, they will be there to work through problems together with the patient and family.^{6,7} There is a profound difference between facing an uncertain future with caring, skilled partners and facing it alone.

One of our goals in working with the dying is to help them try to achieve a "good death."⁸⁻¹⁰ The meaning of this idealized concept may be highly individual, but there are likely to be some common objectives. The first is to die in relative physical comfort, both out of pain and in a clear state of mind. A second objective is to die supported by and connected to important persons in one's life; there may be unfinished business with these persons that can be settled during this intense time. In addition, dying can be an opportunity to resolve spiritual conflicts, to put one's life in perspective, and to gain understanding of life's meaning and purpose. Finally, most notions of a good death include an eventual acceptance of death's natural place at the end of life.

In fact, relatively few deaths contain all these idealized elements,^{2,11} yet most deaths can be made tolerable if not comfortable.

Diseases can be unnervingly unpredictable in their variation, and many persons have led complex lives that may not permit resolution of longstanding spiritual or interpersonal conflicts and peaceful acceptance of death. Although the struggle may be messy, filled with uncertainty and partial solutions, the process is usually acceptable to dying patients and their families when attended by committed, skilled care givers.

Some dying patients have witnessed harsh deaths, and seek reassurance from their physicians that they will be spared extremes of suffering.^{11,12} Common fears are of dying in severe pain or of suffocating. Other apprehensions involve feelings of dependence, humiliation, or disintegration of the self. These trepidations need full exploration and a general commitment that care givers will do everything possible to prevent and, if necessary, respond to these terrifying outcomes. The vast majority of patients will not have their worst fears realized, so reassurance and skilled care are all that is required. But, infrequently, some patients find themselves dying in abject misery in spite of our best efforts to comfort and palliate. These patients who "fail" intensive comfort care test our commitment not to abandon.

REPORT OF A CASE

An 80-year-old man was diagnosed as having stage IIIB metastatic adenocarcinoma of the lung. He initially chose experimental chemotherapy, and had a partial response that made him relatively symptom free for 12 months. The disease then

recurred in his cervical spine and neck, and he received palliative radiation therapy that temporarily relieved the associated pain. At this time, he was admitted to a home hospice program.

The patient was a recently retired, self-employed businessman. He was a fighter who initially wanted to try aggressive, curative therapy, but was also willing to explore and accept hospice care when hope for positive results from disease-oriented intervention was no longer realistic. Because of long years in which work took precedence over family life, his relationships with his children were often strained. He had lost his wife 10 years earlier to cancer, and in his eyes she had died a "bad death." He hoped that he could get to know his children better before he died, and he worried that he, like his wife, would die in severe pain or "out of his mind." His children accepted the role of primary care givers in the hospice program.

The patient's initial 3 months in hospice contained all the elements of a good death. Although he had increasing pain that had both visceral and neuropathic components, he achieved good control with a combination of around-the-clock oral opioids and tricyclic antidepressants. He had regular home visits by the hospice nurses and his primary care physician to assess and adjust the regimen. He and his children had long, meaningful talks, and felt closer to and better understood by each other than they ever had before. As the disease progressed, and the patient became weaker, he achieved an acceptance of and readiness for death. He was a religious

man who hoped and believed he would be joining his wife in the afterlife.

At about the fourth month of home care, the patient began to experience excruciating pain in his neck and chest. He got no relief from daily increases in the dose of oral opioids; adjustments in adjuvant pain relievers, including tricyclic antidepressants, antiseizure medications, mexilitene, and steroids, were not helpful. He was unable to sleep, eat, or move without severe pain, and he saw himself dying much as his wife had. Feeling desperate and out of control, he cried out to his physician: "You promised me I wouldn't die like this!" He was no longer afraid of death, and actually wished for it as far preferable to the state in which he found himself.

He was admitted to the hospital to bring his pain under control. Each hour he begged for help in escaping the pain that had enveloped his life, while the health care team searched for solutions. Specialists in pain management and palliative care were consulted, and a wide range of possibilities were explored, from rapidly increasing doses of intravenous opioids to neurosurgical procedures. The patient was clear that he wanted no further invasive interventions and that he would welcome the sedation that might come from increasing doses of opioids. By increasing the intravenous opioid infusion every 30 minutes, his pain was controlled within 12 hours; however, with his treatment, he became somnolent, paranoid, and hallucinatory. When the dose of opioid was lowered to the point where his mental state was more lucid, the severe pain returned. Changing opioids did not resolve the dilemma. Attempts to mitigate his agitation with benzodiazepines and phenothiazines were unsuccessful. In spite of the health care team's best efforts, it was clear that he was dying a bad death.

After discussions with his family, who now served as his proxy, the patient was sedated to unconsciousness with a barbiturate infusion. There was agreement that this is what he would want, given his situation. When the infusion was cut back, the terror and hallucinations

returned. He was kept sedated and "allowed to die" over the next several days.

Having witnessed his suffering and knowing his wishes, his family was very appreciative of our willingness to provide this solution. The days before his death, during which he was sedated, were not unpleasant, as those who had been close to him came by to pay their respects. Yet there was something unsettling about the process. Several family members found it absurd and even cruel to force him to linger when death was the inevitable outcome. Many commented that we would never put our pets through such a process because of its apparent senselessness. Yet every person involved with the patient knew that this was better than allowing the continuing disintegration and humiliation they had all witnessed.

GAPS BETWEEN GOALS AND REALITY

Although skillful and aggressive comfort care is generally believed to be effective,¹³⁻¹⁷ the empiric data to support this assertion are sparse. Survey data suggest that some bad deaths stem from fear and lack of knowledge and skill on the part of the physicians and nurses in using pain medicines and other effective methods of treating the dying.¹⁸ The answer suggested by these data is to better educate health care providers; to increase access to hospice programs and other palliative services; and to clarify laws and to remove regulatory barriers such as triplacate prescriptions so that physicians will not be fearful about prescribing high doses of opioids when indicated. We fully concur with these strategies.

But not all bad deaths can be attributed to a lack of skill and knowledge on the part of the physicians and nurses, nor to a lack of appropriate resources.^{19,20} Diseases can be extraordinarily diverse in their manifestations, and unforeseen dilemmas emerge every day as we learn new ways to help people to live a little longer. Furthermore, individuals vary considerably in their tolerance for and willingness to accept pain, nausea, dependence, seda-

tion, and the myriad other potential sources of anguish faced by the dying.

Two main goals that we establish with our dying patients is that their pain will be managed and that they will remain as mentally alert and as functional as possible until their death.¹³⁻¹⁷ Although this is not the same as guaranteeing a pain-free death, it is a commitment to treat pain aggressively. We can generally be more reassuring about pain relief than we can about other symptoms such as nausea, vomiting, open wounds, or dyspnea, but as our patient's death illustrates, achieving this goal without unacceptable adverse reactions is occasionally impossible. Very limited empiric data about pain relief in hospice programs suggests effectiveness of 50% to 100%.²⁰⁻²³ Our experience suggests that acceptable pain relief can be achieved about 98% of the time, which is reassuring unless you are unfortunate enough to be among the unrelieved 2%. One wonders how our patient's death and pain control would be coded in such a quality-of-care study. It had elements of both a "good" and a "bad" death, as he had good pain control most of the time but had a period before death when the pain and his personhood were out of control. Longitudinal phenomenologic descriptions of patients' experiences in hospice programs may help us better understand the complex realities faced by dying patients and their families.

It is more difficult to know how to respond to unacceptable dependence, humiliation, and personal disintegration when they are encountered. Physicians, no matter how skilled they are or what their resources are, cannot promise that such experiences will not occur. We can, however, try our best to acknowledge and address these tragedies when we encounter them. When our patient was experiencing severe pain and, later, delirium, he was literally living a nightmare. The need for the health care team to act was obvious, but the appropriate course of action was not. When our patient was no longer in pain, we could not use unrelieved pain to justify increasing his opioids to the point where sedation or death would

provide relief. The principle of "double effect," an ethical cornerstone in the use of high-dose pain medication, requires that our intervention be intended purely to relieve pain and that any contribution to a patient's death be inadvertent and unintended.²⁴⁻²⁶ The shift to a barbiturate infusion was then also justified under double effect, since the intent was to help our patient escape the terror of his hallucinations, even if it indirectly contributed to his death.

If we define suffering broadly enough, as we must, then we have to include the care provider's commitment to join the patient in confronting the existential, emotional, and spiritual as well as the physical elements of suffering. It would be presumptuous and absurd to believe that physicians or hospice staff members have the ability to resolve all such issues. Many times, one or two dimensions of suffering dominate the patient's experience. Practitioners have an obligation to address each patient's unique form of agony, and to respond as best they can. It is unknown how often patients die bad deaths dominated by torment that is not physical.

The fear of a bad death can terrify those who have witnessed severe suffering in a loved one and face a terminal illness themselves. Although most will not have their worst fears realized, the possibility can create dread that can dominate the experience of dying and limit opportunities for growth and connection. For some, simply sharing their apprehensions and anxieties provides sufficient reassurance. Others may ask whether the physician will be willing to ease death if suffering and disintegration occur at the very end.^{11,12} Physicians must look within their own moral framework and experience as they try to deal compassionately with these patients without violating their own beliefs and values.

WAYS IN WHICH WE CURRENTLY EASE DEATH

The doctrine of double effect relies on a sharp distinction between intentions and consequences.²⁴⁻²⁷ In-

terventions that are intended to have a "good" primary purpose, such as the relief of suffering, can be justified even if they have unintended "bad" consequences, such as contributing to a patient's death. Such bad effects can even be anticipated as long as they are not intended. This distinction has freed physicians to provide high doses of opioid analgesics to patients who are dying in pain, even if this intervention indirectly contributes to an earlier death. In practice, one can frequently find a pain regimen that provides sufficient relief without compromising the patient's consciousness or life span, but here again data are lacking. *Double effect* has recently been extended to the use of barbiturate sedation to treat patients who are tormented in dimensions other than pain.²⁸ The primary intent of this intervention is to relieve suffering, and the sedated patient is then allowed to die of his or her disease, the barbiturates, pneumonia, and/or dehydration since he or she can no longer eat or drink. To remain within the confines of the double effect, death in these extreme circumstances may be *foreseen*, but must not be *intended*.

Patients also have the right to refuse potentially life-sustaining treatment, and to stop it once it is started.²⁹⁻³¹ This right is justified under the basic tenet of informed consent—that patients have sovereignty over what happens to their own bodies. Thus, patients whose lives depend on dialysis, mechanical ventilation, feeding tubes, or any other treatment may stop that treatment even if their primary intention is to die. Such deaths are not considered suicides; rather, these patients are allowed to die of their underlying disease. Although physicians' roles in these matters are considered "passive" and "indirect,"^{24,27} physicians report that they feel very "active" when they take patients off mechanical ventilators and discontinue other treatments, especially if death quickly follows.³⁴ Nonetheless, there is wide ethical and legal acceptance that competent patients have the right to stop treatments that are life-sustaining, even when a wished-for death

is the immediate consequence, provided it is truly an informed decision.²⁹⁻³³ In certain circumstances, this right has been expanded to surrogate decision makers for incompetent patients.

The logic used in the right to refuse treatment has recently been extended in both theory³⁵⁻³⁸ and a narrative account³⁹ to the right to stop eating and drinking. It is argued that patients who want to die because their life has become intolerable should have the possibility of starving or, more accurately, dehydrating themselves to death. Presumably, the physician would ensure informed consent, including full consideration of alternatives, and then comfort and relieve symptoms as the process unfolds. The physician's role in these deaths would be passive, and the patient would be allowed to die a natural death (not suicide) from dehydration. Such processes have a defined time course and are reported to be relatively comfortable for patient and family, provided there is clear agreement at the outset.³⁵⁻³⁹ These actions may be ethically, morally, and clinically complex, however, since patients making these choices need not necessarily be terminally ill. Yet this possibility at least provides a potential escape for those who see death as preferable to life as they are forced to live it.

IMPORTANCE AND LIMITATIONS OF THESE SOLUTIONS

Health care providers caring for severely ill and dying patients must be familiar and comfortable with the use of high-dose opioids and with the competent patients' right to refuse or discontinue any treatment. If we agree that barbiturate sedation and voluntary dehydration are also acceptable, we should educate physicians, nurses, and patients about these possibilities. Without clarification of the ethical and legal status of the latter two interventions, it is likely that many health care providers will be reluctant to offer or recommend them.¹⁸

These options, if publicized and openly talked about, would reassure many terminally ill patients

(and others) who fear a bad death. It makes concrete our willingness to provide an escape from most of the adverse circumstances that patients can imagine. It would also allow a widely acceptable response to those relatively few patients who reach a point where they welcome death as preferable to their present and foreseeable future life. It may not be the method they would choose if all options were available, but at least continued agony would not be enforced. The possibilities of barbiturate sedation and voluntary dehydration would also be of value to those physicians and patients who find great meaning in the current ethical distinction between an active and a passive role in assisting dying, and who find directly assisting death and suicide to be immoral even in the face of irreversible anguish. Although they severely test the edges, these methods stay within the confines of the double effect and the right to refuse treatment, and patients could be considered to have been allowed to die. Even if laws change to permit physicians to more directly assist in hastening death, acceptance of such change will occur slowly. In addition, we will still need the widest range of options so that actions are congruent with the values of care givers and patients.

A limitation of our current solutions, particularly if barbiturate sedation and voluntary dehydration are excluded, is that they are discriminatory based on arbitrary aspects of the patient's disease.^{19-24,25-40} It is permissible to indirectly help patients to die if they are in pain or if they are dependent on life-sustaining treatment, but there may be other patients who are subject to even greater agony and do not have that possibility. If they seek death, it will be pejoratively labeled a *suicide*, and if compassionate people (care givers or family) choose to assist them, they will be vulnerable to legal prosecution if their actions are discovered.

The option of barbiturate sedation and terminal voluntary dehydration clearly broadens the range of suffering that can be addressed. It would allow incurably ill, tormented patients who are not in severe pain and who are not on life supports to have a potential es-

cape. However, for many patients, dying sedated to the point of unconsciousness would be unacceptable. Consciousness and interpersonal connection are fundamental to many persons, and lying in a bed sedated, passively dehydrating, waiting for death, may feel humiliating. A central principle in the care of the dying is to individualize care as much as possible. If we are going to ease death, why not do it in a forthright manner consistent with the values of the persons involved?

Furthermore, barbiturate sedation and terminal voluntary dehydration stretch our principles close to the breaking point.⁴¹ Do our intentions with barbiturate sedation stay within the confines of the double effect? Is a wished-for death under those circumstances really unintended, or even a "bad" outcome? Are the differences between this act and voluntary active euthanasia worth preserving? Should the discontinuation of eating and drinking be considered a variation on the right to refuse treatment, or is it a form of suicide? Is *suicide* the correct term for such actions? Clearly, such an act cannot be judged without the motives, intentions, and circumstances of the actors being taken into consideration. Sometimes, stopping eating and drinking to seek death should be considered a form of suicide (eg, by a depressed patient or a patient with anorexia nervosa), and other times consistent with allowing to die (eg, a terminally ill patient in agony who has no other options). Some dying patients would prefer a quick, explicit act to end their lives rather than a solution that requires them to go through a period of sedation and dehydration prior to death. Yet even these patients would usually prefer a sedated death to continued, unrelieved torment.

CHALLENGES

1. *Physicians must be fully educated about comfort care treatments and accepted options for easing death.* All physicians who care for severely ill and dying patients must become educated about current pain and symptom relief methods that have been developed through hos-

pice and palliative care movements¹³⁻¹⁷ and must know how to access physicians and others with special expertise when unusual problems present. They must also understand that a patient's basic right to refuse treatment includes the possibility of stopping life-sustaining treatments when they no longer meet the patient's goals.²⁹⁻³³ If we decide that barbiturate sedation and terminal voluntary dehydration are legitimate options of last resort, then we should educate physicians about their acceptability and how they should be utilized. If we acknowledge that some patients reach the point where their anguish is so extreme and their future prospects are so grim that they need an escape, then we must help care givers work through these circumstances with patients. Although sometimes patients reach this point as a result of inadequate symptomatic treatment or because an unrecognized, potentially treatable problem has arisen,^{11,12} infrequently it occurs despite excellent palliative care. Workers in the field must acknowledge and better understand these rare circumstances without denying their existence or oversimplifying the problem.

2. *Be sure that current ethical distinctions are clinically meaningful and morally worth preserving.* All treatments that will likely result in the patient's death, whether direct or indirect, intended or not, should be interventions of last resort. In our view, the method used is much less important than the process of caring and problem solving that preceded it. The treatment chosen should be consistent with the values of the patient and the physician, especially if it involves his or her active participation. Concepts like the double effect may be pivotal in determining some individual's decisions, whereas for others these distinctions may sometimes seem self-deceptive and meaningless.

3. *Safeguards must be defined for any treatment that results in a patient's death.* Although there are important distinctions between the methods described herein and more direct physician-assisted death, each results in the patient's

death. Decisions of this import must be entirely in the best interests of the patient, as free as possible from adverse external influences. It is for this reason that all such decisions, whether they be to discontinue life-sustaining treatment, barbiturate sedation, voluntary dehydration, or active physician-assisted death, should incorporate safeguards.⁴²⁻⁴⁶ These safeguards would include the following: (1) The patient must be fully informed about his or her condition, prognosis, and treatment choices, including more conventional comfort care options. (2) The patient's thinking must be clear and rational, and a psychiatrist should be consulted if there is a suspicion that there is distortion by depression or other mental disorder. (3) An independent second opinion must be obtained from a person knowledgeable about palliative care. Since these decisions have such profound consequences, it is important to ensure that the patients are fully informed and that all alternatives have been explored.

4. *A bad death should be considered a medical emergency.* Dying patients need health care providers who will face the future with them no matter what happens.⁴⁷⁻⁵⁰ Most of the time, the careful application of comfort care principles and techniques helps to achieve a death that is tolerable if not always ideal. Infrequently, patients reach a point where they seek death because they feel humiliated, and sense that they are disintegrating as persons with no other escape. This state of being is fundamentally disturbing to patients, families, and care givers. Although it may not always be within our power to resolve such experiences, it should be considered a medical emergency that requires an immediate, creative response. In the intensive care unit, when a person's life is at stake, we show no restraint in our willingness to act on the patient's behalf. In the midst of such bad deaths, the patient's personhood is at stake. We must show that same sense of immediacy and lack of restraint by using all our personal and medical resources to find a solution that is acceptable to the patient. It is the ultimate expres-

sion of our commitment not to abandon the dying.

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The views expressed by the authors do not necessarily reflect those of the University of Rochester or its Department of Medicine.

REFERENCES

- Wanzer SH, Adelstein SJ, Cranford RE, et al. The physician's responsibility toward hopelessly ill patients. *N Engl J Med*. 1984;310:955-959.
- Wanzer SH, Federman DD, Adelstein SJ, et al. The physician's responsibility toward hopelessly ill patients: a second look. *N Engl J Med*. 1989;320:844-849.
- Seale CF. What happens in hospices: a review of research evidence. *Soc Sci Med*. 1989;28:551-559.
- Wallston KA, Burger C, Smith RA, Baugher RJ. Comparing the quality of death for hospice and non-hospice cancer patients. *Med Care*. 1988;26:177-182.
- Rhymes J. Hospice care in America. *JAMA*. 1990;264:369-372.
- Quill TE, Cassel CK. Nonabandonment: a central obligation for physicians. *Ann Intern Med*. 1995;122:368-374.
- Cassel EJ. *The Nature of Suffering and the Goals of Medicine*. New York, NY: Oxford University Press Inc; 1991.
- Aries P. *The Hour of Our Death*. New York, NY: Oxford University Press Inc; 1981.
- Loxterkamp D. A good death is hard to find: preliminary reports of a hospice doctor. *J Am Board Fam Pract*. 1993;6:415-417.
- Nuland SB. *How We Die: Reflections on Life's Final Chapter*. New York, NY: Alfred A Knopf Inc; 1994.
- Quill TE. "Doctor I want to die: will you help me?" *JAMA*. 1993;270:870-873.
- Block SJ, Billings JA. Patient requests to hasten death: evaluation and management in terminal care. *Arch Intern Med*. 1994;154:2039-2047.
- Walsh TTD. Symptom control in patients with advanced cancer. *Am J Hospice Palliat Care*. 1992;6:32-40.
- Cohen MH, Johnston-Anderson A, Krasnow SH, Wadleigh RG. Treatment of intractable dyspnea: clinical and ethical issues. *Cancer Invest*. 1992;10:317-321.
- Cohen SR, Mount BM. Quality of life in terminal illness: defining and measuring subjective well-being in the dying. *J Palliat Care*. 1992;8:40-45.
- Broadfield L. Evaluation of palliative care: current status and future directions. *J Palliat Care*. 1988;4:21-28.
- Patt RB, ed. *Cancer Pain*. Philadelphia, Pa: JB Lippincott; 1993.
- Solomon MZ, O'Donnell L, Jennings B, et al. Decisions near the end of life: professional views on life-sustaining treatments. *Am J Public Health*. 1993;83:14-23.
- Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York, NY: WW Norton & Co Inc; 1993.
- Kassing GA. The nonnecessity of euthanasia. In: Humber JM, Almeder RF, Kassing GA, eds. *Physician-Assisted Death*. Clifton, NJ: Humana Press; 1993:25-45.
- Dobratz MC, Wade R, Herbst L, Ryndes T. Pain efficacy in home hospice patients: a longitudinal study. *Cancer Nurs*. 1991;14:20-26.
- Saunders C. Pain and impending death. In: Wall PD, Melzack R, eds. *Textbook of Pain*. New York, NY: Churchill Livingstone Inc; 1984:472-478.
- Ventatrida V, Ripamonti C, De Conno F, Tamburini M, Cassileth BR. Symptom prevalence and control during cancer patients' last days of life. *J Palliat Care*. 1990;6:7-11.
- Rachels J. Active and passive euthanasia. *N Engl J Med*. 1975;292:78-80.
- Brody H. Causing, intending, and assisting death. *J Clin Ethics*. 1993;4:112-117.
- Marquis DB. Four versions of the double effect. *J Med Philos*. 1991;16:515-544.
- Kamm F. The doctrine of double effect: reflections on theoretical and practical issues. *J Med Philos*. 1991;16:571-585.
- Troug RD, Berde CB, Mitchell C, Gner HE. Barbiturates in the care of the terminally ill. *N Engl J Med*. 1992;327:1678-1681.
- Meisel A. Legal myths about terminating life support. *Arch Intern Med*. 1991;151:1497-1502.
- Miller OK, Coe RM, Hyers TM. Achieving consensus on withdrawing or withholding care for critically ill patients. *J Gen Intern Med*. 1992;7:475-480.
- American College of Physicians Ethics Manual. Third Edition. *Ann Intern Med*. 1992;117:947-960.
- American Medical Association Council on Ethical and Judicial Affairs. Decisions near the end of life. *JAMA*. 1992;267:2229-2233.
- Glanz L. Withholding and withdrawing treatment: the role of the criminal law. *Law Med Health Care*. 1987;1988:15:231-241.
- Edwards MJ, Tolle SW. Disconnecting a ventilator at the request of a patient who knows he will then die: the doctor's anguish. *Ann Intern Med*. 1992;117:254-256.
- Printz LA. Terminal dehydration: a compassionate treatment. *Arch Intern Med*. 1992;152:697-700.
- Andrews M, Bell ER, Smith SA, Tischler JF, Veglia JM. Dehydration in terminally ill patients: is it appropriate palliative care? *Postgrad Med*. 1993;93:201-208.
- Sullivan RJ. Accepting death without artificial nutrition or hydration. *J Gen Intern Med*. 1993;8:220-224.
- Pearlman RA. Forgoing medical nutrition and hydration: an area for fine-tuning clinical skills. *J Gen Intern Med*. 1993;8:225-227.
- Eddy DM. A conversation with my mother. *JAMA*. 1994;272:179-181.
- Brock DW. Euthanasia. *Hastings Cent Rep*. 1993;76:585-589.
- Quill TE. The ambiguity of clinical intentions. *N Engl J Med*. 1993;329:1039-1040.
- Quill TE, Cassel CK, Meier DE. Care of the hopelessly ill: potential clinical criteria for physician-assisted suicide. *N Engl J Med*. 1992;327:1380-1384.
- Miller FG, Quill TE, Brody H, Fletcher JC, Gostin LO, Meier DE. Regulating physician-assisted death. *N Engl J Med*. 1994;331:119-123.
- Baile WF, DiMaggio JR, Schapira DV, Janofsky JS. The request for assistance in dying: the need for psychiatric consultation. *Cancer*. 1993;72:2785-2791.
- Sullivan MO, Youngner SJ. Depression, competence, and the right to refuse life-saving medical treatment. *Am J Psychiatry*. 1994;151:971-978.
- Quill TE, Sussman B, Earold SS. Discontinuing an implantable cardioverter-defibrillator as a life-sustaining treatment. *Am J Cardiol*. 1994;74:205-207.

Mr. CANADY. Thank you, Dr. Quill.
Ms. Coleman.

STATEMENT OF DIANE COLEMAN, J.D., M.B.A., EXECUTIVE DIRECTOR, PROGRESS CENTER FOR INDEPENDENT LIVING

Ms. COLEMAN. Most proponents of physician-assisted suicide for the terminally ill would say a representative of the disability community does not really belong here today, but in fact 40 individuals and organizations have endorsed this testimony, including the National Counsel on Independent Living; ADAPT; the World Institute on Disabilities; the ARC, formally the Association for Retarded Citizens; and Justin Dart, the father of the Americans With Disabilities Act.

Court after court has already declared that people with disabilities are essentially the same as people with terminal illnesses based on our perceived low quality of life. Many cases involve people with quadriplegia often unnecessarily locked away in nursing homes.

No court questioned the suicidal decisions of Elizabeth Bouvier, David Rivlin, Larry Macoby. The court superficially concluded that those individuals were not treatable. They were granted a so-called right to die without being offered adequate supports for living. This highly publicized tip of the iceberg and disabled people are beginning to feel that we are riding on the *Titanic*.

A west coast mother recently killed her brain-injured teenage daughter. The judge said her actions were understandable, that other parents could be expected to act in the same way, and he sentenced her to community service.

A U.S. Government report on child abuse recently found that children with disabilities are twice as likely to be abused as non-disabled children.

Assisted suicides from homes have reinforced public prejudice and fear regarding disability, labeling it pitiful, helpless, hopeless, miserable, and inherently undignified. This is an insult to our lifestyles.

Experienced people with disabilities have learned that there is more to life than toileting independently. Physicians must not be granted the power to decide who will be given suicide prevention and who will not. Research shows that physicians dramatically underestimate quality of life for people with disabilities compared to our own assessments.

According to a Dutch governmental report, in the Netherlands in 1990, 5,491 persons, including over 1,400 competent persons, were given lethal injections without consent because of such express reasons as low quality of life, no prospect of improvement, and the family could not take anymore.

In the United States, involuntary, passive euthanasia of people with mental disabilities is already common. Medical rehabilitation specialists report that quadriplegics and other significantly disabled people are dying wrongfully in increasing numbers because emergency room physicians withhold aggressive treatment.

Disabled people who use ventilators report that they are increasingly asked by medical personnel to consider "do not resuscitate" orders and withdrawal of life support. Children with nonterminal

disabilities are killed by the denial of routine treatment. People with relatively mild disabilities are denied lifesaving treatment. Indeed, the ninth circuit court decision, in effect, recognizes assisted suicide as an acceptable solution to the economic burdens of health care. The so-called right to die has become the duty to die.

Kevorkian has stated, "The voluntary self-elimination of mortally diseased and crippled lives taken collectively can only enhance the preservation of public health and welfare."

Many proponents of physician-assisted suicide believe that adequate safeguards can be adopted. If so, as a matter of equal protection, then they should be willing to allow physician-assisted suicide for any citizen after those safeguards have been observed.

However, no one has proposed that physician-assisted suicide be made available to all citizens on a nondiscriminatory basis. The fact is that they are willing to risk the lives of hundreds of thousands of severely disabled people who are not terminally ill in order to secure a right to assisted suicide for others.

People with disabilities protest this cavalier devaluation of our lives. With today's cutbacks in health care and the human service safety net, and with growing isolation from the supports our families can no longer easily provide, people's fears of aging, illness, disability, and the dying process are understandably growing.

But particularly in the absence of a constitutional right to physician care, a right to physician-assisted suicide is not the answer. We ask all who care about social injustice to believe us when we state that disability-based discrimination in this culture is deep seated, virtually unconscious, pervasive, and overwhelming. This discrimination against millions of Americans must be acknowledged, understood, and reversed long before we can discuss expanding the ways in which society's unwanted can be killed.

We can only call upon this Congress and the good people of this Nation to resist. We are the proverbial canaries in the coal mine. If we are declared expendable, who will be next?

[The prepared statement of Ms. Coleman and Gill follows:]

PREPARED STATEMENT OF DIANE COLEMAN, J.D., M.B.A., EXECUTIVE DIRECTOR,
PROGRESS CENTER FOR INDEPENDENT LIVING AND CAROL GILL, PH.D., CHICAGO IN-
STITUTE OF DISABILITY RESEARCH

Most proponents of physician-assisted suicide would say that a representative of the disability community does not really belong on this panel today. They would say that physician-assisted suicide pertains to people who are terminally ill, not disabled.

The concerns of people with disabilities were similarly dismissed as irrelevant in the context of withdrawal of life-sustaining treatment or "passive euthanasia." Nevertheless, courts did not carefully protect non-terminal people with disabilities from a too hasty "final exit." Indeed, court after court declared that people with disabilities were essentially the same as people with terminal illnesses, stating that routine disability-related health care was artificially prolonging life, or that it did not matter how extended the individual's life-expectancy might be if their quality of life rendered their life "meaningless." This occurred in numerous appellate court cases involving people with quadriplegia, often locked away in nursing homes without hope of in-home support services, and it even occurred in a case involving a woman with cerebral palsy.

No court, or professional whose judgement the courts respected, examined the suicidal feelings of Elizabeth Bouvia, David Rivlin, Larry McAfee, Hector Rodas or Kenneth Bergstedt. All courts

attributed the individual's desire to die to their physical disabilities per se rather than to events and circumstances in their lives, such as a miscarriage, loss of spouse and confinement to nursing homes. All courts superficially concluded that the individual's despair was not suicidal, not treatable or deserving of appropriate intervention. These individuals were granted a so-called "right to die" without being offered adequate supports for living. These highly publicized cases are the tip of an unexplored iceberg, one that proponents of physician-assisted suicide prefer to ignore. But the legal foundation for applying physician-assisted suicide to non-terminal people with disabilities is already firmly entrenched in our judicial system, and disabled people are beginning to feel that we are riding on the Titanic.

1) People with disabilities do not have adequate protection from either the courts or disability organizations. The courts have consistently excused parents who have murdered children with disabilities. A woman in Wisconsin escaped sentencing after admittedly starving her son with cerebral palsy to death. She said she was responding to family pressure and the message of a T.V. show on euthanasia. A west coast mother recently killed her brain injured non-verbal teenaged daughter. The judge said her actions were understandable, that other parents could be expected to react in the same way. He sentenced her to community service. Meanwhile, disability watchdog organizations are losing funding. There have never been enough of these to serve people with

disabilities adequately; now many are forced to shut down.

2) People with disabilities and incurable chronic diseases have experienced a long history of persecution and genocide. At the turn of the century, Chicago's Ugly Law ordered people with visible disabilities to hide themselves from public view. In the 1930's, 200,000 people with disabilities were put to death by Nazi physicians who were inspired by the contemporary euthanasia movements of England and the U.S. Three years ago, a European judge ordered a hotel to refund money to a vacationing couple because they claimed their holiday was ruined by the presence of disabled people in the dining room. A physically disabled German man committed suicide after verbal and physical assaults by skinheads. There has been a rise in hate crimes against people with disabilities, internationally. A U.S. government report on child abuse recently found that children with disabilities are twice as likely to be abused as children who are nondisabled, simply because their disabilities. Suffice it to say, contempt for life with disability is very much around us. In this context, we should be extended more protections of our lives, as a minority group at risk, instead of fewer protections.

3) Assisted suicide will not remain confined to the imminently dying. Individuals and groups who have spearheaded this push for assisted suicide have clearly intended people with disabilities to be targeted once laws are relaxed for terminally ill people. In

Final Exit, Hemlock Society founder Derek Humphrey writes: "What can those of us who sympathize with a justified suicide by a handicapped person do to help?...When we have statutes on the books permitting lawful physician aid-in-dying for the terminally ill, I believe that along with this reform there will come a more tolerant attitude to the other exceptional cases." Kevorkian has openly admitted that he designed his suicide device as an answer for quadriplegics. He has said that he perceives physical disability as a cause of extreme human suffering that can be addressed by "medicide." He also argued, as did the Nazis, that society will benefit from the deaths of incurably disabled people. Chillingly, he wrote: ". . . the voluntary self-elimination of individual and mortally diseased or crippled lives taken collectively can only enhance the preservation of public health and welfare." The courts have not prevented this man from following through on his intention to "enhance" society by eliminating people with disabilities who despair in the face of society's crushing oppression.

4) Assisted suicide enthusiasts have reinforced public prejudice and fear regarding disability. They describe our physical status or our simple need for human assistance, tools and technology as "pitiful," "helpless," "hopeless," "miserable," and inherently "undignified." This is an insult to our lifestyles. For example, many people with disabilities routinely manage incontinence through a variety of methods advertised in numerous disability magazines. These negative labels also promote myths about disability and

"quality of life." Experienced people with disabilities have learned that there's more to life than toileting independently. Research consistently indicates that "quality of life" is determined by social supports and meaningful involvement in one's environment, not degree of disability. Most people with disabilities say that public misconceptions about disability trouble them far more than their physical limitations. If promoters of assisted suicide genuinely cared about people with disabilities, they would stop contributing to these negative public attitudes. Instead, they exploit disability prejudice in their public statements and expensive political advertisements to frighten the public into endorsing assisted suicide.

5) As long as people with disabilities are disenfranchised and treated as unwelcome and costly burdens on society, assisted suicide is forced "choice." Assisted suicide is not a free choice as long as people with disabilities are denied adequate healthcare, affordable personal assistance in our own homes, assistive technology, equal education, nondiscriminatory employment, and free access to our communities' structures and transportation systems. Based on recent developments in both public and private managed care, it is already possible in some states for impoverished disabled, elderly and chronically ill people to get assistance to die, but impossible for them to get shoes, eyeglasses, and tooth repair. Indeed, the 9th Circuit Court decision in effect recognizes assisted suicide as an acceptable solution to the

economic burdens of healthcare. The so called "right to die" has become the "duty to die," with Court approval.

6) The great majority of problems that lead people with disabilities, chronic conditions, and even terminal illnesses to seek hastened deaths are remediable through other means, such as assisted independent living outside of nursing homes, sophisticated pain management, death counseling for individuals and families, augmentative communication technology, hospice support, etc. Unfortunately, our nation's health care system has not responded adequately or consistently to these important human needs. Most citizens, particularly poor citizens, must fight for access to health care every step of the way. Many physicians have limited knowledge or skills in pain management, and no knowledge of even the most simple and inexpensive disability-related technology and services. To legalize assisted suicide in a country that has been a pioneer in suicide prevention is a backward step into primitiveness.

7) Physicians must not be given the power to decide who lives and who is escorted to death. As disabled historian Hugh Gallagher warns, the Nazi experience demonstrates how easily compassionate and well-educated physicians can lose their moral compass. Furthermore, research shows that physicians learn very little about disabled people during medical training, they are poor at diagnosing treatable depression, they are often uninformed about

options such as pain management and supported living for people with disabilities, and they have a high suicide rate, themselves. Moreover, research shows that physicians consistently and dramatically underestimate quality of life for people with disabilities compared to the assessments of people with disabilities themselves. In addition, most individuals with disabilities report longstanding problems with physicians, citing disability prejudice, ignorance about the disability lifestyle, and medical abuse as commonly issuing from physicians. It is unlikely that doctors will become more careful and accountable for our lives when current permissive attitudes about physician-assisted suicide are given the status of law.

8) The 2nd Circuit Court decision illustrates the logic that propels us down the slippery slope to endangerment. In numerous court cases since 1985 involving "passive euthanasia", "right to die" proponents have argued that passively withdrawing life supports was neither suicide nor mercy killing -- it was just letting nature take its course. Now, the Court's decision articulates that there is no essential difference between assisted suicide and death from withdrawal of life supports. Will the next decision challenge the distinction between assisted suicide and mercy killing, or the distinction between voluntary requests to die and proxy requests or decisions made without consent at all? That is exactly what happened in the Netherlands--a country often cited by assisted suicide proponents as the model for the U.S.

Specifically, according to a Dutch governmental report in 1990, 5,941 persons were given lethal injections without consent. Of those, 1,474 were fully competent, according to their physicians. In 8% of the cases, doctors admitted there were unexplored options. Regardless of options, they euthanized unconsenting patients because of such express reasons as "low quality of life." "no prospect of improvement," "the family could not take any more" (Doctor Assisted Suicide and the Euthanasia Movement ed. by Gary E. McCuen).

9) In fact, people with disabilities have already been endangered by relaxation of laws and policies protecting their lives. Medical rehabilitation specialists report that quadriplegics and other significantly disabled people are dying wrongfully in increasing numbers because emergency room physicians judge their quality of life as low and, therefore, withhold aggressive treatment. Disabled people who need ventilators are often not offered assisted breathing as an option. Those who already use ventilators report that they are increasingly asked by medical personnel to consider "do not resuscitate" orders and withdrawal of life support. Children with non-terminal disabilities who never asked to die are killed "gently" by the denial of routine treatment. People with relatively mild disabilities are routinely denied life saving organ transplants. Many people with disabilities are terrified that managed care will further abridge their already limited options for life-extending treatments. Oregon's attempt to ration healthcare

based on "quality of life" judgements (judgements made by nondisabled people) demonstrated how quickly the deck can be stacked against the lives of people with costly conditions. In the Netherlands, where disabled children, and adults with multiple sclerosis, quadriplegia, and depression are commonly assisted to die, disabled citizens express fear. Some carry wallet cards asking not to be euthanized. Dutch physicians follow a practice not to offer assisted ventilation to quadriplegics. Those who visit the U.S. have expressed surprise to see quadriplegics actively engaged in life with the use of costly portable ventilators and mouth-controlled power wheelchairs. Not surprisingly, the hospice movement is virtually non-existent in the Netherlands. When assisted death is a ready solution there is little incentive to develop life-enhancing supportive services for "incurables."

10) Many proponents of physician-assisted suicide have expressed the belief that adequate safeguards can be adopted to protect vulnerable people from various forms of pressure and abuse if the practice is legalized in conformance with the 2nd and 9th Circuit court opinions. This view is at best naive and at worst deliberately misleading. Similar statements were made during the last decade in the context of the withdrawal of life-sustaining treatment, but no meaningful safeguards have been established. In particular, people with disabilities are notably absent from hospital medical ethics committees. If, in fact, proponents of

physician-assisted suicide believe that adequate safeguards against treatable suicidal feelings can be established, then they should be willing to allow physician-assisted for any citizen, regardless of their health status, after those safeguards have been observed. However, no one has proposed that physician-assisted suicide be made available to all citizens on a non-discriminatory basis. Indeed, science fiction movies have been made depicting the atrocities of such a practice in futuristic society. But it appears that such practices are acceptable today if "only" applied to a loosely defined group of seriously ill or impaired individuals. The fact is that proponents of physician-assisted suicide are willing to risk the lives of hundreds of thousands of severely disabled people who are not terminally ill in order to secure a right to active euthanasia that would effectively shield them from legal scrutiny of their conduct. People with disabilities protest this cavalier devaluation of our lives.

11) Assisted suicide is discriminatory. As a policy, it singles out ill and disabled people as fitting subjects for dying. Meanwhile, neither the public nor health professionals endorse this so-called "autonomous" decision for young, healthy Americans. If there is a constitutional right to control one's death through assistance, it should apply to all citizens, not just those judged (or misjudged) to have a deficient life.

12) Assisted suicide is classist. Those who are used to privilege,

and the control over one's life that privilege affords, will benefit from having one more choice--the choice to die by their own schedule. Such individuals expect to control all aspects of their lives. Either they cannot truly fathom the experience of disenfranchised groups, or they are willing to risk the safety of many (society's poor and oppressed) to ensure their personal access to more options. On the other hand, those who lack privilege, who are socially devalued and feared, those who are denied meaningful options to live, will be endangered by legalization of assisted suicide. The historical reality of disabled people's experience is that society does not adequately support our lives unless pressured by strong legal sanctions. The Congress of the United States acknowledged that disabled people are a discrete and insular minority in its passage of the Americans with Disabilities Act in 1990. We are entitled to the equal protection of the laws under the 14th Amendment of the U.S. Constitution. The laws that protect our lives have often been the only buffer between us and annihilation. Now, under the guise of a 14th Amendment protection of an alleged liberty interest in assisted suicide, a certain class of people will be denied the 14th Amendment's equal protection of laws providing for suicide prevention when one poses a danger to oneself.

13) There is virtually no research on suicide and suicidal wishes in people with disabilities. This is a direct reflection of how little our lives are valued. Physicians, such as Timothy Quill,

who propose guidelines for "safe" assisted death admit that the social consequences of assisted suicide are unknown. Yet they argue that legalizing physician assisted suicide will open up this area for investigation. At what cost to whom? It is hard to imagine a physician defending this kind of research design for any other group of people. Why are ill and disabled persons dispensible?

14) People with disabilities and incurable illnesses deserve the same social supports and commitment to suicide intervention as any other citizen. Although proponents of assisted suicide often emphasize its rationality, suicidologists tell us there is always a powerful emotional force and the pain of unmet needs underlying the desire to die. Most death requests, even in terminally ill people, are propelled by despair and treatable depression. As two such experts stated recently (Herbert Hendin and Gerald Klermand in Amer J. of Psychiatry, Jan. 1993):

Advocates of physician-assisted suicide try to convey the impression that in terminally ill patients the wish to die is totally different from suicidal intent in those without terminal illness. However, like other suicidal individuals, patients who desire an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly a depressive condition. Strikingly, the overwhelming majority of the terminally ill fight for life to the end.

Some may voice suicidal thoughts in response to transient depression or severe pain, but these patients usually respond well to treatment for depressive illness and pain medication and are grateful to be alive.

In fact, periods of depression are common in people adjusting to new or progressive disabilities. Such depression and concomitant suicidal feelings can persist for months or even years if not addressed with support and treatment from those experienced in working with people with disabilities.

15) Women with disabilities will be particularly endangered by the legalization of assisted suicide. Research indicates that women with disabilities are even more socially devalued than disabled men. We are also more likely to bear the stresses of poverty and social isolation. As women, we are twice as likely as men to suffer from depression. A study by DisAbled Women's Network (DAWN) in Canada indicates that rates of depression and suicide may be even higher for women with disabilities than other women due to our multiple stresses, our high incidence of abuse, and our internalization of society's message that we are useless and inferior as women. If anyone doubts that women will be exploited and endangered by assisted suicide, that doubter should study Kevorkian's "clients." The first eight were all middle aged or elderly women with chronic illnesses and disabilities. Many said they feared being a burden on others. An autopsy on one of them

revealed no evidence of any physical illness. Women with disabilities are going to be the first to feel a "duty to die."

16) People with disabilities in our country are increasingly caught in a perilous bind. On one side, recent assaults on the Americans with Disabilities Act and the Individuals with Disabilities Education Act threaten our hope of equal opportunity, and managed care threatens our access to basic healthcare and long-term services. On the other side, sanctioned assisted suicide allows our healthcare professionals to offer the final solution.

Conclusion

People have always been afraid to face the practical difficulties and losses associated with aging, illness and disability. In today's society, with cutbacks in health care and the human service "safety net", and with growing isolation from the supports our families could once more easily provide, people's fears are understandably growing. As a culture, we must address these very real human needs and fears.

But, particularly in the absence of a constitutional right to physician care, a right to physician-assisted suicide is not the answer. While a few may have all the options that money can buy and choose the final solution with complete understanding and freedom, the majority who are offered this option are people that

society is all too ready to abandon as too costly and unproductive-people who can only depend on the protection of the law. The depth and breadth of this abandonment is only understood by those who live it everyday.

We ask all who care about social injustice to believe us when we state that disability-based discrimination in this culture is deep-seated, virtually unconscious, pervasive and overwhelming. This discrimination against millions of Americans must be understood and reversed, in ways that few can even envision, long before we discuss expanding the ways in which society's unwanted can be killed.

But if, in the prevailing confusion and despair of our culture, physician-assisted suicide will become a constitutional right for some, then it must be a constitutional right for all, nondisabled as well as disabled. The same safeguards, or lack of safeguards, that apply to some must apply to all. Those who have asserted the 14th Amendment's right to liberty as the legal foundation for a steady expansion of the right to die in the last decade cannot be allowed to continue to ignore the 14th Amendment's Equal Protection clause.

The assertion that people with disabilities are not threatened by physician-assisted suicide is false, based on virtually every court precedent to date, as well as actual practice in our culture today.

The fact that its proponents continue to dismiss and marginalize the input of the disability community on this topic leads us to believe that they may actually feel that our untimely deaths are ultimately acceptable in the interest of the "greater good."

Then we can only call upon this Congress and the good people of our nation to resist our being singled out, to resist this form of discrimination. We are the proverbial "canaries in the coal-mine", the barometers of our value system. If we are declared expendable, who will be next?

PERSPECTIVE ON ASSISTED SUICIDE

Walk a Mile in My Wheelchair



Quality of life consists of more than the physical; just because someone is disabled doesn't mean his life has no value.

By BEN MATTLIN

I am a 33-year-old married Harvard graduate with a new baby daughter. Threatened to hurl myself off a tall building, would an emergency medical team respond? And if one did, would I be offered counseling—or carbon monoxide?

I was born with a neuromuscular disability and use a wheelchair. With all the recent euthanasia news—Dr. Jack Kevorkian's acquittal and new trial and two federal court decisions favoring assisted suicide—I don't feel safe.

It may be constitutionally protected, but the right to die seems dangerous to those of us who are not ideal physical specimens.

I am not terminally ill. Both the April 2 decision by the 2nd U.S. Circuit Court of Appeals in New York and the March 6 decision by the 9th U.S. Circuit Court of Appeals in San Francisco permit assisted suicide only for "a competent, terminally ill adult." But Judge Stephen Reinhardt, writing for the majority in San Francisco, went on to say that death is more

humane than continuing to live in "a childlike state of helplessness."

They are not the same thing, though, this "state of helplessness" and being terminally ill. I have lived my whole life in such a state, needing assistance for eating, bathing, using the toilet. The humane thing to do is to help, not presume that my life isn't

worth living.

Kevorkian isn't concerned with whether his clients' conditions are terminal. On Aug. 4, 1993, for example, after his medical license had been revoked in Michigan and California and Michigan's law against assisted suicide was in effect, Kevorkian aided the suicide of a 30-year-old who had recently become quadriplegic. Thomas Hyde wasn't terminally ill, not really ill at all. Nor was he in pain. His condition was roughly the same as mine.

In the new trial, Kevorkian stands accused in the death of Marjorie Wentz, 58, who, Kevorkian admits, was not terminally ill. Rather, Wentz "claimed after a series of surgeries to be suffering intense vaginal pain that they [prosecutors] contend was psychosomatic," the New York Times reported.

Granted, the people seeking assisted suicide want to die. And I believe in autonomy and self-determination. I am pro-choice. But what happens when able-bodied people attempt suicide?

Why is their choice considered irrational? Why is a disabled person's suicide choice more readily judged sane?

Kevorkian would argue that he is ending suffering for people with no options. Tell that to Stephen Hawking, the physicist who has advanced amyotrophic lateral sclerosis, writes best-selling books, travels around the world and recently divorced his wife to marry his nurse. To say someone has no options just because doctors are stumped is medical arrogance. Quality of life is determined by more than physical condition.

To be sure, not everyone can be a Stephen Hawking. Which is precisely why Kevorkianism is so frightening. Does Kevorkian realize how hard it is for the average disabled person to feel valued in this society?

What I'm calling for is clarity. The right to die is appropriate only if it isn't clouded by fear and ignorance of disabilities. The dangers are potentially enormous. Euthanasia, after all, was one step toward the Holocaust. If doctors, judges and juries continue to cast doubts on the worth of people with disabilities, I fear for the one in six Americans (according to the census) who has a disability. If Kevorkian is truly concerned about us, why doesn't he join the cause of disability rights?

Ben Mattlin is a writer and editor in West Los Angeles.

The following individuals and indicated organizations endorse the testimony of Diane Coleman, J.D. and Carol Gill, Ph.D. to be presented before the Constitution Subcommittee of the House Judiciary Committee on April 29, 1996, concerning the danger which physician-assisted suicide presents to people with disabilities. (An asterisk by the name of the organization indicates endorsement.)

Name	Organization	Address	City	State	Zip
Robert Kibbey	*CCDI	401 E. Adams	Springfield	IL	62761
	Coalition of Citizens with Disabilities in Illinois				
Ann Fero	*STATEWIDE INDEPENDENT LIVING COUNCIL OF IL	132 S. 4 th ST	SPRINGFIELD	IL	62701
Clare McKee		10 Sheffield Ave.	Newington	ME	04240
	Coalition of Citizens with Disabilities	310 N. 11 th St	Austin	TX	78701
	Coalition of Citizens with Disabilities	25 N. 1 st St	Phila	PA	19107
Sue Koiles					
MSND	MIND/INSTITUTE ON MENTAL DISABILITY	510 16 th STREET	SUITE 100 OAKLAND	CA	94612-1500
Marlene Dwyer		720 E. Ann Arbor	MI	48104	
Marlene Dwyer		717 11 th Street	Santa Monica	CA	90402
Marlene Dwyer		5980 Richmond Hwy #311	Alexandria	VA	22304
Marlene Dwyer	Suffolk Univ	Eight Ashburton Place	Boston	MA	02108-2711

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Kathleen Kellerman	Tri County Partnership for Aging	67 E. Ben Street	Wilmington	PA	15301
Bob KAFKA	INSTITUTE FOR Disability Access	1319 Lanna Sa Or Suite 101	Austin	TX	78704
Cassie James	Liberty Resources Inc	4001 Conshohocken Ave	909 Phila	PA	19131
John P. M.		407 W. 35th St	WASHTON	DC	20007
William Sprung		150 W. 80 St - 4A	New York	NY	10024
Debra Luthin	AM CONGLTION OF CITIZENS WITH DISABILITIES	101 S. 2nd St	St. Louis	MO	63101
John H. Turner	Turner Resources CIL	7110 Penn Ave	Pittsburgh	PA	15208
William Sprung		1376 Penn Cr Mph	MI	48106	
Bob Enteen	Natl MS Society	733 3rd Ave	NY	NY	10017-3283
Cheryl C. Lippman	parenting disabilities Nat'l Council on Disability				
Richard B. Committee	on Mental Retardation, Committee for Handicap				

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Name	Organization	Address	City	State	Zip
Larry Coveau	Parent of disabled child	380 Apackct	Fremont	CA	94539
Robertson Bennett	Access Living	3950 W. Lakeshore Dr.	Chicago	IL	60613
Zully F. Alvarez	Chicago Foundation for Women	6033 N. Shoreland Blvd	Chicago	IL	60660
Barbara Otto	The Art Coalition	25 W. Monroe	Chicago	IL	60606
Mary Mitchell		5822 Roswell Rd.	Opt. 1 Mordern, Ill.		53701
Mike Joyce		4 North Allen St.	Madison, Ill.		53705
STEVE JACKSON III		384 SECOND AVE	Long Branch	NJ	07740
Susie Epstein	Disability Awareness Service	509 Terrace	Austin	TX	78704

Withdrawing Life-Sustaining Treatment from People with Severe Disabilities Who Request It: Equal Protection Considerations Diane Coleman, J.D.*

In 1983, the Southern California affiliate of the American Civil Liberties Union (ACLU) sued on behalf of Elizabeth Bouvia, a young woman with cerebral palsy. The ACLU sought a court order requiring a hospital to provide intravenous morphine to Ms. Bouvia while she starved herself to death.¹ The *Bouvia* case was the first highly publicized right-to-die court proceeding to involve a conscious individual with substantial but not terminal disabilities.

Although Ms. Bouvia had experienced a series of personal setbacks including a miscarriage, spousal abandonment, loss of certain financial benefits, and loss of an opportunity to pursue a master's degree, these events were not addressed as factors precipitating a suicidal crisis subject to clinical intervention and treatment.² Her very public request for

*Co-Director, Center for Assistive Technology Project, Access Services of Middle Tennessee, Inc., Nashville, Tennessee; Member, Tennessee State Advisory Committee to the U.S. Commission on Civil Rights, Advisory Committee, Tennessee Human Rights Commission, Organizer, American Disabled For Attendant Programs Today (ADAPT), B.S., University of Illinois, Champaign Urbana, 1976; J.D., University of California at Los Angeles, 1981; M.B.A., University of California at Los Angeles, 1981, wheelchair user since age eleven due to spinal muscular atrophy.

¹*Bouvia v. Superior Court*, 225 Cal. App. 2d 297, 298, 306 (Cal. App. 1980).

²Paul K. Langerman, *Disability Issues: Assisted Suicide and Social Responsibility*, 3 *Issues in Law & Med.* 141, 151-54, 156 (1987).

assistance to die was not interpreted as the proverbial "cry for help." Instead, the court, the ACLU attorneys, psychiatrists, professionals, and the media assumed that Ms. Bouvia was rationally preferring death over the life with disabilities she had experienced since birth.¹

A number of individuals with disabilities attended the trial court proceedings in the Bouvia matter and protested the court petition by picketing the ACLU's offices. The lower court denied Ms. Bouvia's right-to-die petition.²

The appellate court reversed by ruling that Ms. Bouvia's request did not involve an assisted suicide.³ Nevertheless, by the time the appellate decision was handed down, Ms. Bouvia's suicidal crisis had passed, and she did not carry out her plan of self-starvation.⁴ Unfortunately, in the course of the proceedings, she did not receive appropriate psychological counseling or other support services, her limbs contracted from disuse, preventing her from using the motorized wheelchair she had used to get through college, and she became dependent on morphine.⁵

While Ms. Bouvia has dropped out of the public eye, her case continues to serve as legal precedent for similar court rulings across the United States. A recent right-to-die ruling was issued in the Nevada case of Kenneth Bergstedt.⁶ The Nevada Supreme Court relied, in part, on the Bouvia analysis in determining that Mr. Bergstedt's petition to direct his caregivers to disconnect his ventilator was not a request for suicide, but rather was a request for natural death.⁷ When considering requests for assistance in dying by persons with severe disabilities, other courts have made the same "if's not suicide" determination.⁸

Why do courts conclude that petitions for an assisted death by persons with severe but nonterminal disabilities do not implicate suicide? The answer may be that these courts elect not to apply the equal protection constraints on state action found in the federal and state constitutions. By declining to apply protections against suicide, and

¹Bouvia, 225 Cal. Rptr. at 915.

²*Id.* at 297.

³*Id.* at 306.

⁴The last press report stated that Bouvia had given up her efforts to starve to death because "it would take too long," and she left the pain and side effects would be unendurable. She "still wants to end her life, but said that now is not the time." Myrna Chover, *Bouvia Still Wants the Right to Die*, L.A. Ave. 111S (Times May 23, 1986), at 11.

⁵Langmore, *supra* note 2, at 150.

⁶McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

⁷*Id.* at 626.

⁸*Id.* (citing, cases), many advance directive laws specify that decisions to refuse life-sustaining treatment, when exercised according to statutory provisions, are not a bad suicide. ALAN MINSKY, *The Right to Die* 69 (1989) & 1 *supra* (supp. 1992).

indeed by encouraging or approving death for persons with disabilities, while continuing to extend suicide protections to persons without disabilities, the courts risk denying persons with disabilities the equal protection of the laws.⁹ Only by ruling out suicide in these right-to-die cases can courts avoid a direct confrontation with equal protection principles.

This article examines the practice and consequences of treating requests to die by persons with disabilities as rational choices and not as suicidal pleas for help and assistance in living. By selectively ignoring laws and policies for suicide prevention in these cases, courts are applying a double standard for persons with and those without disabilities. This double standard is based on the courts' ill-informed quality of life judgments. The resulting court actions are subject to constitutional challenge for their failure to provide equal protection to persons with disabilities.

Statement of Facts: McKay v. Bergstedt

Kenneth Bergstedt was a thirty-one year old man with quadriplegia who had used a ventilator since the age of ten.¹⁰ He had lived with his parents all his life, though his mother had died some years before his petition to die was filed.¹¹ The court record indicated that he spent his time watching television and writing poetry on a computer.¹² Although other persons with spinal cord injuries at the C-1/C-2 level use wheelchairs,¹³ Mr. Bergstedt was reportedly limited to lying on a gurney most of the time.¹⁴ Apparently, he had never attended school away from home, worked, or socialized much. Nor did he establish contact with the disability community or with persons knowledgeable about options for independent living.

When his caretaker father became terminally ill, the son learned "life in the care of strangers" and being cast "adrift in a sea of indifference" upon his father's death.¹⁵ The father filed a petition in a Las Vegas court on his son's behalf. He requested a court order permitting him to turn off his son's ventilator without liability for murder or wrongful death, and determining that Mr. Bergstedt's request was not suicidal.¹⁶ The court never communicated with Mr.

⁹115 Cases around XIV, § 1.

¹⁰Bergstedt, 801 P.2d at 618, 620.

¹¹*Id.* at 624.

¹²Unanswered Questions, LEXIS-11, RAC, Sept./Oct. 1990, at 22.

¹³*Id.* at 18.

¹⁴Bergstedt, 801 P.2d at 626.

¹⁵*Id.* at 620.

rights to appeal.⁴⁶ These appeals are initiated by families and friends opposed to a death row prisoner's decision to accept a speedy execution by abandoning the death sentence appeals.⁴⁷ In one case, the ACLU even complained that prisoners waiving an appeal were denied adequate counseling services because, if they expressed suicidal feelings, those feelings would be disclosed to prison officials who would then confiscate all their belongings.⁴⁸ Although the Supreme Court ruled in 1976 that Gary Gilmore could terminate his appeals of the death penalty,⁴⁹ Justice Marshall's dissent in that case is noteworthy because it challenges Gilmore's competency to waive his rights:

I can hardly agree . . . that Gilmore has competently, knowingly and intelligently decided to let himself be killed. No adversary hearing has been held to examine the experts' all employed by the State . . . , who have pronounced Gilmore sane.⁵⁰

Indeed, courts may be more likely to call for in-depth examination of suicidal feelings in death row prisoners than in people with severe disabilities.⁵¹

Defining Away the Suicide

How did the Nevada Supreme Court in *Bergstedt* avoid bringing into motion Nevada's laws and practices for preventing suicide and prohibiting assistance for suicide? How did the court release the medical profession from its customary duties to act to prevent suicide? Perhaps the most crucial step in the court's analysis was concluding that Mr. Bergstedt was not suicidal, even though the facts as related by the court evidenced a suicidal intent. In effect, the court defined away the suicide.

Mr. Bergstedt's concerns about his future without his father were apparent to the court:

We . . . note that Kenneth's fear of being left at the mercy of strangers would now present an added challenge to the struggle for quality

⁴⁶The irony is based on the contrast between the ACLU's opposition to waivers of the right to appeal by death row prisoners and the organization's advocacy of a waiver of the right to life-sustaining treatment by Elizabeth Thawra *Pratt v. Jeffers*, 601 F.Supp. 105 (E.D. Pa. 1987). *Avery v. McKehe*, 727 F.2d 964 (6th Cir. 1984); see also Melvin J. Urofsky, *A Right to Die: Termination of Appeal for Condemned Prisoners*, 75 J. Crim. L. & Criminology 553, 568 (1984).

⁴⁷*Pratt*, 601 F.Supp. 41918.

⁴⁸*Gilmore v. Utah*, 429 U.S. 1012 (1976).

⁴⁹*Id.* at 1019 (Marshall, J., dissenting).

⁵⁰Justice Marshall joined a dissenting opinion in *McCain* that favored the surrogate waiver of a patient's right to live even when clear and convincing evidence of a knowing and intelligent waiver by the patient was lacking. 110 S.Ct. at 2863 (Marshall, J., dissenting).

in his life if he had survived, as his devoted and caring father passed away.⁴²

He despaired over the prospect of life without the attentive care, companionship and love of his devoted father.⁴³

It appeared that Kenneth's suffering resulted more from his fear of the unknown than any source of physical pain. After more than two decades under the loving care of his parents, Kenneth understandably feared for the quality of his life after the death of his father.⁴⁴

Fear of the unknown is a common travail even among those of us who are not imprisoned by paralysis and a total dependency upon others. There is no doubt that Kenneth was plagued by a sense of foreboding concerning the quality of his life without his father.⁴⁵ It is not difficult to understand why fear had such an overriding grasp on his view of the quality of his future life.⁴⁶

Nevertheless, the court ignored its own findings of fact. It did not consider Mr. Bergstedt's fears and despair to be factors precipitating a suicidal crisis and thus failed to understand that his request to die could have been more appropriately addressed through psychological, therapeutic, and social service intervention.

Noting that some persons characterized Mr. Bergstedt's petition as a request for "state-sponsored suicide," the court placed great weight on the fact that its "research revealed[] no court declaring it so."⁴⁷ The court defined suicide as "the act or an instance of taking one's own life voluntarily and intentionally; the deliberate and intentional destruction of his own life by a person of years of discretion and of sound mind, one that commits or attempts self-murder."⁴⁸ "As we will attempt to show," the court continued, "Kenneth harbored no intent to take his own life, voluntarily or otherwise. He did not seek his own destruction."⁴⁹

At this point in its analysis, the court attempted to explain the difference it saw between Mr. Bergstedt and a suicidal person:

It is . . . clear that if Kenneth had enjoyed sound physical health, but had viewed life as unbearably miserable because of his mental state, his liberty interest would provide no basis for asserting a right to terminate his own life with or without the assistance of others. Our societal regard

⁴²*Bergstedt*, 881 P.2d at 619 n.1.

⁴³*Id.* at 620.

⁴⁴*Id.* at 624.

⁴⁵*Id.*

⁴⁶*Id.* at 625.

⁴⁷*Id.* quoting *Winters v. Newell*, 682 P.2d 1041, 1043 (Utah, 1984).

⁴⁸*Id.*

for the value of an individual life . . . would never countenance an assertion of liberty over life under such circumstances."⁶¹

The court's sole distinction was that Mr. Bergstedt did not enjoy sound physical health. Thus, the court implied that the reason Mr. Bergstedt viewed his life as "unbearably miserable" was not his mental state—such as his acknowledged fears about his future without his father—but, rather, his physical state.

The court disagreed with Justice Scalia's concurring opinion in *Cruzan* which indicated that suicidal intent is a crucial consideration, whether the individual carries out that intent by withdrawing life-sustaining treatment or by sitting in a closed garage with the car motor running.⁶² The Nevada court argued that suicide is only at issue in cases involving healthy individuals whose intent to die is perceived as reversible. "If they [Justice Scalia's suicidal persons] were physically healthy, society's respect for human life demanded that the state prevent, if possible, their deaths by suicide. . . . [They] enjoyed the prospect of mental rehabilitation that might restore the will to live . . . [and act] from a potentially reversible pessimism."⁶³

Was Mr. Bergstedt's "pessimism" irreversible? If he knew that a personal attendant could assist him in the activities of daily living after his father's death and that he did not have to face life in an institution, would he have chosen death?⁶⁴ It is unclear whether Mr. Bergstedt was ever allowed to pursue a college education or try to get a job—perhaps at home using a modem and his computer—or even given a chance to meet in private with friends. Without inquiring into such obviously important human issues and lacking sufficient disability expertise, the court nevertheless believed that Mr. Bergstedt's pessimism was irreversible and therefore he was not comparable to a "physically healthy" suicidal person.

Yet the court did state that, had Mr. Bergstedt been alive at the time of its ruling, something in the way of additional disclosures about his options would have been required before granting his petition.⁶⁵ The court must have believed this information might have

⁶¹Id.

⁶²Id. at 626 (discussing *HO'S U. at 2862* (Scalia, J., concurring)).

⁶³Id.

⁶⁴For example, over half of the states provide varying amounts of personal assistance services to disabled people through their Medicaid programs. Other states provide such services as part of their vocational rehabilitation programs, and others through several different federal, state, and local grants. The court findings indicate that no such options were explored on Mr. Bergstedt's behalf.

⁶⁵Id. at 626.

made a difference—in other words, that Mr. Bergstedt's pessimism might have been reversible. This possibility was oddly ignored, however, in the court's determination that Mr. Bergstedt was not suicidal.

Depression in a person with severe disabilities is commonly assumed to result from a person's feelings about physical limitations *per se*, such as the inability to walk, dress, eat, or use the bathroom in the same way that nondisabled people do. The belief that the individual's problem is the disability *per se* undermines our society as a whole and the medical/legal professions in particular.⁶⁶

The court emphasized that Mr. Bergstedt depended on a ventilator to breathe.⁶⁷ The fact that he had done so for twenty years without seeking death and could have continued to do so for years in the future was not considered relevant to whether Mr. Bergstedt was experiencing a suicidal crisis.

The court acknowledged that there is no right to commit suicide.⁶⁸ Therefore, the court attempted to provide a test for determining whether a person's refusal of life-sustaining treatment was suicidal and thus impermissible:

To a large extent, a patient's attitude or motive may be judged from such factors as severity of physical condition, diagnosis, prognosis, and quality of life. If a competent adult is beset with an irreversible condition such as quadriplegia, where life must be sustained artificially and under circumstances of total dependence, the adult's attitude or motive may be presumed not to be suicidal.⁶⁹

Therefore, according to the Nevada Supreme Court, the determination of whether a person is suicidal is to be presumptively based not on the degree of emotional and mental distress but on the level of physical capabilities. In fact, it is unclear what, if any, variation in factual circumstances could twer-

⁶⁶As Vegas psychiatrist Jack A. Jurasky reportedly stated in his affidavit filed in the Bergstedt proceeding, "The quality of life for this man is very poor, moderated only by momentary distraction, but forever pained by a future which offers no relief."

⁶⁷Id. at 624, 625.

⁶⁸Id. at 625.

⁶⁹Id. at 627.

⁷⁰Mr. Bergstedt's "expert witness," psychiatrist, might have explored with him independent living or home, and community based service options that would have enabled Mr. Bergstedt to live outside a nursing home. In addition, Mr. Bergstedt might have been given an opportunity to meet other people with quadriplegia who use ventilators, people from whom he might have gained support, ideas, perspective, and aspirations about the with severe disability.

Expanding the Concept of "Natural Death"

The court employed a second line of reasoning to support its conclusion that suicide was not at issue in *Bergstedt*. It analogized Mr. Bergstedt's situation to cases involving painful terminal illness. "Most would consider it unthinkable to force one who is wracked with advanced, terminal cancer to require a therapy regimen that would merely prolong the agony of dying for a brief season...."⁶¹ If the patient with cancer refused treatment, the court asked, "could it seriously be argued that he or she is committing an act of suicide?"⁶² Similarly, the court opined, "Kenneth survived artificially within a paralytic prison from which there was no hope of release other than death."⁶³ Thus, the court concluded that Mr. Bergstedt was only seeking a natural death:

The primary factor that distinguish Kenneth's type of case from that of a person desiring suicide are attitude, physical condition and prognosis. . . . If the desired only to eliminate the artificial barriers standing between him and the natural processes of life and death. . . . [H]e asked no one to shorten the term of his natural life free of the respirator. He sought no fatal poisons to end life or hurry death.⁶⁴

Most states have enacted statutes that endeavor to create a right to a natural death by allowing for the withdrawal of extraordinary life-sustaining measures from incompetent persons who are "terminally ill."⁶⁵ Characterizing Mr. Bergstedt's request as a non-suicidal petition for natural death would theoretically fit his request within the framework of practices permitted under most living will statutes. If this argument is accepted, however, its impact would dramatically alter the way society treats persons whose very existence depends on assorted life-sustaining measures. A policy of masking the suicidal nature of requests to die will only add impetus to efforts to expand the scope of legally acceptable death petitions and will decrease society's resolve to protect persons from self-inflicted harm in an ever-widening range of circumstances.

For example, some states have recently expanded their living will law's definition of terminal condition by adding "irreversible coma" or "persistent vegetative state" to their lists of conditions deemed "ter-

⁶¹Id. 172d at 625.

⁶²Id.

⁶³Id. at 626.

⁶⁴Id. at 625-26.

⁶⁵By the end of 1991, forty-five states, and the District of Columbia had enacted some form of living will law. See *Medical Treatment of Rights of Elderly Patients and Persons with Disabilities*, 1991 *Developments*, 7 *Healthcare Law & Ethics* 407, 425 n.151 (1992).

минал."⁶⁶ This development only blurs the very real distinction between chronic illness or permanent disability on the one hand and truly terminal illness on the other. The media have been especially prone to miss this distinction and often refer to terminal cancer and such nonterminal disabilities as multiple sclerosis and cerebral palsy as virtual equivalents in the "right to die" context.⁶⁷

Moreover, the definition of "extraordinary" treatment is likewise expanding. For example, courts have consistently concluded that a ventilator is an extraordinary means of life support, even though many persons use ventilators and live productive, fulfilling lives.⁶⁸ More recently, courts and legislatures have concluded that a feeding tube, even more common and less intrusive than a ventilator, constitutes artificial, i.e., extraordinary, life support.⁶⁹ Will the courts next determine that dialysis machines and heart pacemakers are extraordinary? Could other forms of life-sustaining treatment eventually be found extraordinary—such as urinary catheters, colostomy bags, or insulin injections?⁷⁰

These trends create a frightening prospect for persons with disabilities. A person with any type of permanent disability now faces the possibility that his or her request to refuse life-sustaining care of any type will be viewed simply as a rational opting for "natural" death simply because the person is disabled. Missed in the analysis will be the option of forestalling the request to enable the person to survive a suicidal crisis and thereby regain a desire to live that might have been submerged by the suicidal crisis itself. Elizabeth Bouvia is still living today partly because the lengthy court proceedings in her case outlasted her suicidal desire to die.⁷¹ Mr. Bergstedt was not so

⁶⁶Id. at 626 n.157 (citing legislative amendments adopted in Louisiana, New Jersey, Ohio, South Dakota, and West Virginia).

⁶⁷See *Debate over Right To Die Reminded*, USA TODAY, Oct. 25, 1991, at A1.

⁶⁸See *Thiamurad Desrosiers*, supra note 14, at 19-21.

⁶⁹See *James Rupp, Jr. & Daniel Aude, Trends in the Law: From Death to Life*, 27 *Health & Law* 1, 13 (1991-92).

⁷⁰A particular note is the case of Bertha Meyer of Honolulu, Hawaii. In 1967, her son, George M. Burnell, petitioned a court to enjoin Ms. Meyer's caregivers from replacing a battery in her pacemaker. He alleged that he would "experience grievous emotional distress if my mother is forced to undergo this elective procedure." Affidavit of Petitioner at 3. In re Meyer (Haw. Ct. Ct. filed Nov. 13, 1967) (No. 87-4031). Mr. Burnell contended that his mother had advanced Alzheimer's dementia and was therefore "dependent on a pacemaker for life support." Id. at 2. He withdrew his petition and consented to replacing the battery only after an attorney for the company responsible for Ms. Meyer's pacemaker intervened by challenging the petition. George M. Burnell, *Interference Stops Woman from a Natural Death*, BOSTON GLOBE, April 1969, at B6, 7.

⁷¹See supra text accompanying note 6.

fortunate and was assisted to die before the factors precipitating his crisis were addressed or resolved.⁷¹

The Role of Societal Assistance in Suicide

Having resolved by redefinition the problem of suicide, the Bergstedt court neatly eliminated any issues concerning assisted suicide. Mr. Bergstedt's father and other caregivers could not be charged with assisting suicide if suicide was not involved.

There was another form of suicide assistance at issue in *Bergstedt*—the editorial and public commentary encouraging death for Mr. Bergstedt. As noted by the Nevada Supreme Court, the majority of news editorials about the case favored an expeditious resolution of the court proceedings so that Mr. Bergstedt could be assisted to die. The coverage was so one-sided that the court apparently felt pressed to comment on the possible adverse impact on Mr. Bergstedt:

We have read with dismay editorials that pressed for an expeditious accommodation of Kenneth's desire to disconnect his respirator. We would have much preferred reading expressions of concern for the value of Kenneth's life and the various sources of organizational support that might have been explored in an effort to provide Kenneth with incentives to live. We trust that Kenneth did not conclude from such editorials that his life was without value or purpose or that meaningful alternatives did not exist.⁷²

If a nondisabled person informed another that he or she wanted to die, such an expression would commonly be considered a "cry for help."⁷³ Psychologists who study suicide have found that the suicidal person is always ambivalent about the desire to die and that many factors can tip the scale in one direction or the other at any particular moment.⁷⁴ Historically, society has thrown its weight in favor of life, perhaps based on a collective intuition that societal support, in one direction or the other, can mean the difference between life and death. Now, apparently, that societal preference for life is shifting towards death.

Thus, should it be surprising that the court which so severely chided the media nevertheless summarily dismissed the state's interest in "serving Mr. Bergstedt's life? The court concluded:

The State's interest in the preservation of life relates to meaningful

⁷¹ *Bergstedt*, 801 P.2d at 619 n.1. Unlike the *Reuter* case, which took the courts years to resolve, Mr. Bergstedt was allowed to die just three and a half months after judicial review of his death request was initiated.

⁷² *Id.* at 632 n.9.

⁷³ Thomas J. Maroney et al., *supra* note 32, at 118 n.681.

⁷⁴ *Id.* at 108-11.

life. Insofar as this State's interest is concerned, the State has no overriding interest in interfering with the natural processes of dying among citizens whose lives are irreparably devastated by injury or illness to the point where life may only be sustained by contrivance or radical intervention.⁷⁵

Refusal of Medical Treatment

Instead of approaching Mr. Bergstedt's petition as a request to sanction assisted suicide, the Nevada Supreme Court confined itself to a simple application of the right to refuse medical treatment. Under the "right to refuse" approach, courts have had no difficulty granting petitioners' requests to die.⁷⁶

The right to refuse treatment has been anchored by some courts in evolving constitutional privacy rights,⁷⁷ but most courts favor two other theoretical foundations. One foundation is the common law doctrine of informed consent; the other is the due process liberty against irrational state interference.⁷⁸

Under the law of informed consent to treatment, a corollary of the right to refuse treatment, the refusal must be informed, consensual, and issued voluntarily by a person legally competent to do so.⁷⁹ In *Bergstedt*, the court reported that "141 psychiatrist examined Kenneth and found him to be competent and able to understand the nature and consequences of his decision."⁸⁰ The psychiatrist did not purport to have any disability expertise or to have examined with Mr. Bergstedt the nature of his past experiences, the basis of his fears about the future, or any options for independent living. The court nevertheless found it sufficient that Mr. Bergstedt knew he had quadriplegia, he would always have quadriplegia, and he would die if his ventilator was removed.⁸¹

Right-to-die courts have also readily found competency and voluntariness, the other elements of informed consent.⁸² However, the analysis employed tends to be conclusory and fails to consider the need for in-depth psychiatric evaluation. If a nondisabled person refuses

⁷⁵ 801 P.2d at 626.

⁷⁶ See *Cruzan v. Harmon*, 760 S.W.2d 408, 413 (Mo., 1988) (en banc) (court decisions granting right to die have been "nearly unanimous").

⁷⁷ *Thompson v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 634 (Mass. 1986).

⁷⁸ *Cruzan*, 110 S.Ct. at 2051 & n.7.

⁷⁹ See Kevin R. Wadd, Note, *Determining Patient Competency in Treatment Refusal Cases*, 24 Ga. L. Rev. 733, 739 n.35 (1990).

⁸⁰ *Bergstedt*, 801 P.2d at 620.

⁸¹ *Id.*

⁸² See Wadd, *supra* note 79, at 744-51.

life-sustaining treatment, he or she is likely to be found incompetent unless there are religious reasons such as a faith-based refusal of blood transfusions.⁴¹ In such cases, the courts have usually approved the refusal as long as the patient's motivation was truly religious.⁴² In nonreligious circumstances, however, suicidologists generally consider life-threatening choices to be proof of irrationality, clinical depression, and other indicators of incompetence.⁴³

Yet death choices made by persons with severe disabilities are considered rational and not subject to clinical intervention. Even a recent miscarriage and spousal abandonment—factors likely to cause a suicidal crisis for anyone—were ignored as clinical indications for evaluating whether Elizabeth Bouvia was competent or clinically depressed.⁴⁴ Similarly, right-to-die courts fail to consider whether the threat of confinement in a nursing home, other forms of societal discrimination, or media coverage overwhelmingly biased in favor of assisted death for a person with severe disabilities would eliminate through duress the voluntary nature of a decision to die.

Having concluded that Mr. Bergstedt was competent to exercise a right to refuse treatment, the court noted that the right is not absolute and must be weighed against four countervailing state interests:⁴⁵

- (1) the State's interest in preserving the sanctity of all life, including that of the particular patient involved in a given action; (2) the State's interest in preventing suicide; (3) the State's interest in protecting innocent third persons who may be adversely affected by the death of the party seeking relief; and (4) the State's interest in preserving the integrity of the medical profession.⁴⁶

The *Bergstedt* court found that none of these interests outweighed Mr. Bergstedt's interest in refusing treatment. With respect to the interest in life, the court held that "as [a person's] quality of life diminishes because of physical deterioration, the State's interest in preserving life may correspondingly decrease."⁴⁷ As already noted, the court concluded that Nevada's interest in suicide prevention was not implicated because Mr. Bergstedt's conduct did not constitute suicide.⁴⁸ The court also

⁴¹See *Mirret*, supra note 11, at 115-16, for cases involving refusal of blood transfusions. When the tenets of a patient's religion are unclear, the patient's religious affiliation is not relevant. *In re Jones*, 529 A.2d 434, 443 (N.J. 1987).

⁴²*Mirret* et al., supra note 73, at 111-22.

⁴³See Langmuir, supra note 2, at 151-54.

⁴⁴State interests must be at least minimally evaluated in these cases, because the courts as government actors are being asked to knowingly approve of, and thus participate in, conduct that would typically be private (suicide) and perhaps unlawful (assisting suicide).

⁴⁵Bill 172d at 622-26.

⁴⁶*Id.* at 622.

⁴⁷See, supra text accompanying notes 42-49.

dismissed as inapplicable the state's interest in protecting third parties, since Mr. Bergstedt's father reportedly understood and reluctantly agreed to his son's decision.⁴⁹

Regarding the medical profession, the court explained that: "[I]f the State has an unquestioned duty to see that the integrity of the medical profession is preserved and that it is never allowed to become an instrument for the selective destruction of lives deemed to have little utility."⁵⁰ This interest was not analyzed further. The court simply noted that the medical profession is in unanimous agreement about the right to refuse treatment.⁵¹

A Fifth State Interest Identified

The court also found that a fifth state interest was implicated in the case. Apparently in response to an amicus brief filed on behalf of a disability rights group,⁵² the court identified an interest in encouraging "charitable contributions for the humane care and treatment of citizens stricken with various maladies and disabilities."⁵³ At this point, having already concluded that Mr. Bergstedt was not suicidal, the court wrote: "It appeared to us that Kenneth needed some type of assurance that society would not cast him adrift in a sea of indifference after his father's passing."⁵⁴

Therefore, the court would have required that Mr. Bergstedt be informed about his "care alternatives" by a "responsible health care provider or representative of Nevada Department of Human Resources."⁵⁵ The requirement is inconsistent, however, with the court's conclusion that a person such as Mr. Bergstedt was distinguishable from a suicidal person because the latter's request to die arises from a potentially reversible pessimism. Nevertheless, the court indicated, in effect, that Mr. Bergstedt's attitude about his life and future, whether pessimistic or not, might have been reversed by more information about his care

⁴⁹Bill 172d at 627.

⁵⁰*Id.* at 627-28 (emphasis added).

⁵¹*Id.* at 628. Why did the court not consider whether Mr. Bergstedt had an equally strong interest against involuntary placement in a nursing home?

⁵²The Amicus Curiae Brief of the American Disabled for Access Power Today of Southern California was submitted by the National Legal Center for the Medically Dependent & Disabled, Inc., but was not accepted by the court because of late filing (*id.* at 628 n.6 (Springer, J., dissenting)). Judge Springer cited the brief numerous times in his dissenting opinion, and the majority seems to have repudiated it and even incorporated certain arguments raised in the brief.

⁵³*Id.* at 628.

⁵⁴*Id.*

⁵⁵*Id.*

alternatives.⁹⁸ Yet the court failed to consider whether such information would be accurate or thorough if provided by someone without disability expertise or experience.

Procedural Issues

The *Bergstedt* court then recommended procedures to be applied in right-to-die cases involving adults unless and until the Nevada legislature acted.⁹⁹ The court explained that "persons in Kenneth's situation should not be subjected to such a burdensome process" as the one he had been through in the Nevada courts.¹⁰⁰ Therefore, the court established the following procedures: Two non-attending physicians must examine the adult to determine and certify in writing that (a) the patient is mentally competent to understand his or her prognosis and was properly informed thereof, as well as of treatment alternatives and the consequences of refusing medical treatment; (b) the patient's condition is irreversible or has reached the extent to which the condition may be improved through medical intervention; (c) the patient is or reasonably appears to be free of coercion or pressure; and (d) if the patient is nonterminal, he or she was apprised of the care options available.¹⁰¹

Once two non-attending physicians certified that these conditions were satisfied, then, in the case of a person who was not terminally ill, the state interests would be weighed by a district court judge. There would be no right of appeal unless the judge ruled that the state interests outweighed the patient's interests in nontreatment.¹⁰²

The court noted that the Nevada attorney general had agreed with Mr. Bergstedt and "accordingly assumed only a token adversarial stance on appeal."¹⁰³ Nevertheless, the court suggested that the legislature might appropriately provide that a deputy attorney general could weigh the state interests in these matters, and a case-by-case judicial determination would be unnecessary. Again, the only circumstance requiring

⁹⁸There is another irony here. Apparently the court was unaware that there are hundreds of nonprofit independent living centers, protection and advocacy agencies, and other groups funded by federal grants to assist disabled individuals in dealing with the ignorance and discrimination pervading the medical and social service system purporting to serve them. Recommending that the state disallow options other than nursing home care or death is as unhelpful as a court recommending in the 1950s that people of color subject to racial prejudice seek information about their rights from J. Edgar Hoover, a staunch opponent of the African-American civil rights movement.

⁹⁹801 P.2d at 630-31.

¹⁰⁰*Id.* at 629.

¹⁰¹*Id.* at 630.

¹⁰²*Id.* at 630-31.

¹⁰³*Id.* at 619.

judicial review would be if the deputy attorney general, or other party assigned to weigh the state's interests, found that such interests outweighed the petitioner's right to an assisted death.¹⁰⁴

Equal Protection Analysis

The majority opinion in *Bergstedt* was vigorously contested by a dissenting justice.¹⁰⁵ The dissent's most telling objection was its claim that the majority practiced unequal treatment by approving Mr. Bergstedt's request to die. According to the dissent, Mr. Bergstedt's "assisted suicide was sanctioned and facilitated only because of his disabled condition."¹⁰⁶ The dissent claimed that negative value judgments about the worth of Mr. Bergstedt's life clouded the majority's perceptions about the suicidal nature of Mr. Bergstedt's request.¹⁰⁷ By changing the majority with "prejudicial treatment,"¹⁰⁸ the dissent articulated an equal protection challenge to the *Bergstedt* holding.

Some commentators have concluded that equal protection problems may arise when a right to die is granted in cases involving persons with disabilities.¹⁰⁹ Courts have routinely cited the fourteenth amendment's liberty and equal protection clauses as bases for assisting people with severe disabilities to die,¹¹⁰ while ignoring the possibility

¹⁰⁴*Id.* at 631 n.9.

¹⁰⁵*Id.* at 632 (Springer, J., dissenting).

¹⁰⁶*Id.* at 635.

¹⁰⁷*Id.* at 633-34.

¹⁰⁸*Id.* at 635.

¹⁰⁹See, e.g., James Bopp, Jr., *Is Assisted Suicide Constitutionally Protected?* 3 *Issues in Law & Med.* 113, 116-17 (1987); Marcia Pearce Burgdorf & Robert Burgdorf, Jr., *A History of Unequal Treatment: The Qualifications of Handicapped Persons as a "Suspect Class," Under the Equal Protection Clause*, 15 *SANTA CLARA L. REV.* 855 (1975); Robert Desiro, *Quality of Life Ethics and Constitutional Jurisprudence: The Denial of Natural Rights and Equal Protection for the Disabled and Incontinent*, 21 *CONSUMER HEALTHCARE & POLICY* 71 (1986).

¹¹⁰Generally, the argument here would be that an individual possesses a constitutionally protected right to choose death. The state cannot interfere with this constitutional right absent sufficient justification or through undue or to those unable to exercise their right because of incapacity would violate equal protection if based on an arbitrary or capricious classification. Given, however, that the freedom to refuse necessary care is considered a "liberty" and not a fundamental right (*Cruzan*, 110 S.Ct. at 2851 n.7), the U.S. Constitution would demand only a showing of a rational basis for any state limits on the liberty exercise. Placing reasonable limits on the liberty to die in cases involving the risk of suicidal intent and impaired decisional capacity would not offend principles of due process. Indeed, "a State is [not] required to remain neutral in the face of an informed and voluntary decision" (to die). 110 S.Ct. at 2852. In addition, the U.S. Supreme Court has recognized that decisions by incompetent persons are different from decisions by competent persons, thereby warranting additional limits on surrogate decisionmaking to protect incompetent persons from harm. *Id.* at 2856 n.12.

Other jurisdictions are likewise discouraging or eliminating court involvement.¹⁶ As a result, state action is becoming more routine. Society may come to expect and even accept official disregard of protective state policies in right-to-die cases involving suicidal persons with disabilities. Furthermore, as courts and legislatures streamline the path to death for persons with disabilities, moving these cases out of the courtroom and away from the public eye, state action will be more difficult to trace. The window of opportunity for equal protection of people with disabilities will be lowered and eventually closed as more courts withdraw from the right-to-die controversy.

Suspect Class Status of People with Disabilities

Are people with disabilities a "suspect class"? Is there a persuasive analogy between discrimination based on race and discrimination based on disability? By overturning the "separate but equal" doctrine on equal protection grounds,¹⁷ the U.S. Supreme Court bolstered a social and political revolution by the black civil rights movement. Is it conceivable that a court might similarly respond to the increasingly visible disability rights movement by reversing the tide in right-to-die cases on equal protection grounds?

In *Plessy v. Ferguson*,¹⁸ the Supreme Court established the separate but equal doctrine. The "rationale" of the Nevada Supreme Court in *Bergstedt* may be more analogous to the constitutional "reasoning" underlying *Plessy's* separate but equal doctrine than to any modern civil rights law.

While racial oppression remains a social problem today, it is nevertheless difficult to imagine how nine high court justices could once conclude that the separate but equal doctrine would coexist harmoniously with the constitutional guarantee of equal protection. Against a fourteenth amendment challenge, *Plessy* upheld the states' right to pass laws that segregated persons on the basis of race.¹⁹ The Supreme Court acknowledged that the federal government could not discriminate based on race under the fifth amendment.²⁰ The Court refused to extend the duty of providing equal protection for persons of color to the states or the private sector:

We consider the underlying fallacy of the plaintiff's argument to consist in the assumption that the enforced separation of the two

¹⁶ See *In re Lawrence*, 579 N.E.2d 32 (Ind. 1991).

¹⁷ *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954).

¹⁸ 163 U.S. 537 (1896).

¹⁹ *Id.* at 552.

²⁰ *Id.* at 543.

that such assistance may itself violate equal protection.²¹ The remainder of this article considers the equal protection ramifications of *Bergstedt* and other right-to-die decisions. The issues of state action, suspect classification, and strict scrutiny will be addressed.

State Action Requirements

Purely private action is insufficient to implicate equal protection considerations.²² Does governmental approval of and compliance with a private request to withhold or withdraw life-sustaining treatment create the requisite state action? In *Mr. Bergstedt's* case, the answer is yes. The actions of both the lower and higher courts in issuing judicial orders and the involvement of the state attorney in entering a token adversarial appearance and agreeing not to prosecute those assisting *Mr. Bergstedt's* death would constitute state actions.²³ Even the Nevada Supreme Court's proposal to eliminate the judicial role in most cases would not end the state's involvement in Nevada because the state attorney would still have to weigh the state's interests against the petitioner's interests.²⁴

In 1990, a Tennessee court ruled that health care providers could withdraw life-sustaining treatment at the request of a patient and would enjoy legal immunity as long as two non-atending physicians recorded in the patient's medical chart that the patient, whether terminally ill or not, was competent and understood her diagnosis and prognosis.²⁵ In

²¹ These right-to-die rulings may also violate due process guarantees protecting the right to life and the liberty to accept disability-related services. See generally *Boyle & Avila, The Due Process "Right to Life,"* *supra* note 26.

²² *Edmonson v. Leesville Concrete Co., Inc.*, 111 S.Ct. 2077, 2082 (1991).

²³ Judges and attorneys employed by the government to carry out governmental inquiries are state actors, and the tasks of judging and determining whether private decisions would be prosecutable offenses are inherently attributable to the state. *Edmonson*, 111 S.Ct. at 2085, 2086. See also *Henry F. v. Mrs. Day's* of Fish Welfare, 925 F.2d 944 (5th Cir. 1991) (petition on behalf of abused child alleging that district attorney and welfare social workers failed to act on reports of child abuse; sufficiently stated claim of constitutional violation on grounds that state officials' failure to enforce state laws that created entitlement to state protection against abuse interfered with child's interest in that protection).

²⁴ *Boyle*, 601 P.2d at 636-37.

²⁵ *Camble v. Baptist Hosp.*, No. 90-1021 Ill. slip op. (Ill. Apr. 11, 1990). (January Judge Robert Brandt stated in open court that he did not want to see these cases in court. An amicus brief filed in *Camble* by persons with disabilities advised the court that the petitioner was undisturbed about her independent living alternatives. See *Brick Ames*, *Curtis* of American Disabled for Attendant Programs Today (ADAPT), *Thane* (ADAPT), *Deborah Cunningham*, *Steve Hayes*, *Frank McNeal* & *Lorian Smolicz*, *Individuals and members of ADAPT* at B-14. Nevertheless, the court declined to address the disclosure issue, granted the petition (slip op. at 5 n.6), and the resuscitation was turned off the morning after the court's ruling.

cases stamps the colored race with a badge of inferiority. Legislation is powerless to eradicate racial distinctions based on bloodlines based on physical differences. If one race be inferior to the other socially, the Constitution of the United States cannot put them upon the same plane.¹¹¹

Similarly, courts today are holding that the physical differences associated with severe disability have necessary social and legal consequences which cannot be corrected by the Constitution. Right-to-die cases employ a double standard for suicide prevention, one for persons who are valued (those without disabilities) and another for persons who are not valued (those with disabilities, especially of a severe nature). The latter, if suicidal, will be assisted to die without sincere investigation or clinical intervention, while the former will not be. Is this double-standard any more consistent with the U.S. Constitution than the separate but equal doctrine?

The Supreme Court described in *Plessy* the latitude the states would possess in enacting laws based on the physical difference of race:

It is true that the question of the proportion of colored blood necessary to constitute a colored person, as distinguished from a white person, is one upon which there is a difference of opinion in the different states, some holding that any visible admixture of black blood stamps the person as belonging to the colored race, others that it depends upon the preponderance of blood, and still others that the preponderance of white blood must only be in the proportion of three-fourths. But these are questions to be determined under the laws of each state.¹¹²

Is this any different from the latitude granted to the states under *Cruzan*?¹¹³ The Supreme Court's discussion of a person's proportion of African-American blood is shockingly anachronistic. To people with disabilities, however, the Nevada Supreme Court's descriptions of Mr. Bergstedt's disability sound just as biased. In 1895, the legal analysis of the learned Supreme Court was no less a reflection of then-prevailing cultural biases than judicial "reasoning" on disability issues is today.

The following pronouncements of the Nevada Supreme Court are typical of the language found in other right-to-die cases:

[Kenneth's] physical condition was dire. His quadriplegia left him not only ventilator-dependent, but entirely reliant on others for his bodily functions. . . .¹¹⁴

¹¹¹Id. at 551-52.

¹¹²Id. at 552.

¹¹³110 S. Ct. 421, 426-50 (Cruzan v. Hunt, 1991).

¹¹⁴Bergstedt, 801 P.2d at 624.

At the tender age of ten, Kenneth suffered the fate of a quadriplegic.¹¹⁵

[H]e occasionally received limited enjoyment from wheelchair ambulation.¹¹⁶

[T]here is a substantial distinction in the state's insistence that human life be saved where the affliction is curable.¹¹⁷

Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone?¹¹⁸

Today, perhaps most people would find nothing incorrect or wrongful in these words, just as most white persons living in 1895 would not have found fault with the reasoning and language in *Plessy*. That is the nature of prejudice: the one who practices it perceives it as rational and justified.

Our society has progressed, albeit slowly, toward legally recognizing people with disabilities as a "suspect class." The courts and legal commentators have, for their part, detailed the history of discrimination against people with disabilities,¹¹⁹ describing institutional abuses,¹²⁰ forced sterilization,¹²¹ restrictions on marriage,¹²² and other socially sanctioned distinctions based on disability.

The Americans with Disabilities Act of 1990 (ADA) includes a specific congressional finding that:

individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on charac-

¹¹⁵Id. at 620.

¹¹⁶Id.

¹¹⁷Id. at 623 (quoting *Satt v. Perlmutter*, 362 So.2d 160, 162 (Fla. App. 1978) (quoting *Supplement of Belcher v. Sullivan*, 370 N.E.2d 472, 475-76 (Mass. 1977)).

¹¹⁸Id. (quoting *Boone v. Super Ct.*, 225 Cal. Rptr. 297, 305 (Cal. App. 1984)).

¹¹⁹Burgdorf & Burgdorf, *supra* note 109; City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 461-65 (Marshall, Brennan & Blackmun, JJ., dissenting in part) (1985), 1985 L.R. 218 N.W.2d 441 (ND 1974).

¹²⁰NOTES AS N. KIRBY, *THE RIGHT TO BE DIFFERENT* 57 (1971); ALBERT DUKES II, *THE MENTALLY ILL IN AMERICA: A HISTORY OF THEIR CARE AND TREATMENT FROM COLONIAL TIMES* (2d ed. 1949); WALL WALLENSBURGER, *The Origin and Nature of Our Institutional Models, in CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED* (Robert B. Kugel & Wall Wallemburger eds., 1969).

¹²¹See *THE MENTALLY DEVIANT AND THE LAW* 207-49 (Samuel J. Brakel & Ronald S. Rock eds., rev. ed. 1971); CHARLES W. MUNDICK, *Sterilization of the Retarded: A Problem or a Solution?* 62 CAL. L. REV. 917 (1974); LEON N. POTT, *Jeopardy and the Law*, 7 CAL. MAR. L. REV. 290, 290 (1970); see also *Moss v. Clear Ave.*, 58 U.S. 11-45, 11-41, 45, 19 (1972), 6 SUPP. 1901.

¹²²See, e.g., KY REV. STAT. ANN. sec. 402.028(1a); SUPP. 1980; MISS. CODE ANN. § 40-1-402(1a) & (2)(a) (1991).

prevention policies to further society's economic objectives would affect many nondisabled persons as well as persons with disabilities.¹⁴

Proponents of sanctioned and assisted suicide might assert another state interest: advancing personal autonomy in the form of assisted suicide. This interest would be consistent with the liberty to make medical choices recognized in the right-to-die cases. However, if autonomy is to be extended to some, it would have to be extended to all who request it and, to be perfectly consistent, to those who cannot request it.¹⁵

Such a policy would place a disparate burden on indigent women and people of color, as well as people with disabilities, since depression and despair among these groups may often result from poverty, isolation, gender discrimination, and other social conditions. Therefore, under a disparate impact challenge, a policy of assisted suicide "on demand" might well not survive equal protection scrutiny any better than assisted suicide for a "suspect class" of persons.

Conclusion

Over the last decade, courts have considered a number of so-called right-to-die cases involving persons with substantial, though non-terminal, disabilities seeking to have life-sustaining treatment withdrawn. In response, courts have rapidly, and with little or no disability expertise, carved out exceptions to long-standing laws, medical practices, and social policies against assisted suicide. The purported rationale for these

¹⁴ Though "fiscal integrity . . . has legitimate concern of the State . . . [this does not mean that] [g]overnment[] can pursue the objective of saving money by discriminating against individuals or groups." *Lyng v. Nitt Union*, 485 U.S. 360, 373 (1988).

¹⁵ Would recognizing a distinction between passive and active euthanasia avoid this result? It probably would not. In passive euthanasia, death results from the withdrawal of medical treatment; active euthanasia requires the administration of some death-inducing agent, such as a lethal injection. However, current events and legal developments indicate that reliance on the distinction between passive and active euthanasia may be misplaced. If a person on a respirator for twenty years is "terminally ill" simply because he or she depends on that respirator, then what is the distinction between that person and a person on a dialysis machine, a pacemaker, or insulin? Why are the legal definitions of terminal illness expanding? Why are citizens being asked to vote on public referenda authorizing lethal injections? Why is society ambivalent over Dr. Jack Kevorkian's active euthanasia of women with Alzheimer's disease, multiple sclerosis, and a nonterminal pelvic disorder? These developments demonstrate that reliance on the distinction between passive and active euthanasia begs the real question: Which suicidal persons does society want to encourage to live, and which would it prefer to assist to die? Society is answering the real question by making quality-of-life judgments based on deep-seated prejudices against people with severe disabilities and, according to those judgments, determining social policy on suicide.

exceptions—based on tortured premises—is that suicide is not involved in these cases. This trend threatens to silence the call for competent and disability-qualified suicide prevention services and will discourage prosecution of those who assist suicide. This trend is rooted in pervasive and largely unconscious societal prejudices against people with disabilities, reflected most pointedly in the case of Kenneth Bergstedt in Nevada.

Court and legislative actions authorizing assisted suicide for people with disabilities may be challenged under the equal protection clause of the fourteenth amendment. The state action requirement can be satisfied in right-to-die cases, a fundamental right (life) is involved, and people with disabilities may be a "suspect class." The congressional findings accompanying the ADA lend weight to the argument that people with disabilities are a "suspect class" constituting a discrete and insular minority.

If strict scrutiny is applied to right-to-die court decisions employing prejudicial assessments of disability, the decisions must be overturned. The constitutional guarantee of equality requires states to not discriminate against the enjoyment of a fundamental right or against a suspect class except when necessary to serve a compelling state interest by the least restrictive means possible. Approving suicide for persons with disabilities to contain health care costs or to vindicate personal autonomy, for example, would expand the right to assisted suicide to a socially and politically untenable degree. Therefore, court rulings authorizing assisted suicide for people with disabilities cannot withstand a genuine application of equal protection review.

Suicide Intervention for People with Disabilities: A Lesson in Inequality

Carol J. Gill, Ph.D.*

The American commitment to equality, which affirms the value of all individuals and their entitlement to the pursuit of a good life, is by no means a "hands off" ethic. It is backed by a determination to support and protect vulnerable individuals (and, as we have seen recently, even nations) during hardship. America's prominence in suicide prevention is certainly consistent with this tradition.

A different belief system—one that weighs the value of human life in terms of its costs, that idealizes mental and physical superiority, and that endorses termination of weak individuals in the name of "mercy"—is one we tend to associate with other cultures in other places. In reality, we know these beliefs, too, are part of America's history. Some argue that social Darwinism and the eugenics movement are becoming as influential in American thinking currently as when they flourished early in this century.¹

When a culture values human life conditionally, suicide intervention becomes selective. Devalued populations fail to receive rigorous protection, assessment, and treatment.² Already at heightened risk from their oppressed status, devalued people are further endangered by deprivation of psychological support. Current research indicates that unaddressed social stress factors (not any inherent physiological or racial defect) account for high rates of depression and suicide in certain minority groups in the United States.³

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¹Nat. Health. Are Handicapped Infants' Worth Saving? *Vitality*, Vol. 1, Jan. 8, 1991, at 18. Richard J. Neuhaus, *The Return of Eugenics: A Commentary*, *APR*, 1988, at 15-26.

²Richard J. Neuhaus, *The Return of Eugenics: A Commentary*, *APR*, 1988, at 15-26.

³Araceli H. Cui, *The Psychology of Suicide*, 251-58 (1991); *Culture Blamed for Women's Depression*, *CHI. TRIB. DES. 6*, 1990, § 1, at 4; *Disorder History Shows in America's Most at Risk*, *KNOWLEDGE & ACTION*, supra note 2, at 463.

has acquired labels such as "refusal of treatment," a wish to avoid prolonged suffering or dying, a desire to let a terminal disease take its natural course (used in cases of long-term disability lacking any evidence of terminal illness), and "not committing suicide."⁶ The implication is that there is something natural, reasonable, or proper about a disabled person's dying as opposed to a nondisabled person's dying.

Complicating matters is the fact that disabled persons' communications of suicidal intent are frequently confounded by their own negative statements regarding disability. The public misunderstands "right to die" cases in which the troubled individual laments the disability itself or the need for "life supports." Lacking an informed perspective and harboring intense fears of becoming disabled, the public, including judges, ethicists, and media reporters, takes such complaints at face value and looks no further for their significance. Such people readily conclude that the disabled person's wish to die is reasonable because it agrees with their own preconception that the primary problem for such individuals is the unbearable experience of a permanent disability (and/or dependence on life aids). If permanent disability is the problem, death is the solution. In this analysis, the wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is "rational" and, thereby, different from suicides resulting from emotional disturbance or illogical despair.

These assumptions betray a faulty understanding of both living with disability and considering suicide. Addressing the latter, Edwin Shneidman, pioneering researcher and clinician in American suicide prevention, has described suicide as "a multidimensional malaise in a needful individual who defines an issue for which the suicide is seen as the best solution."⁷ He explains that any deliberate act of self-annihilation is suicide, even if effected through the acts of others (e.g., when individuals ask to be killed by others) or coerced (e.g., when captives are forced to kill themselves by the brutality of others). He emphasizes that all suicidal behavior is motivated by need, not reason alone. Although the choice of dying seems logical to the suicidal individual, it is a logic distorted by need, distress, and constricted perception. According to Shneidman and other suicidologists, every suicide, no matter how calm and rational on the surface, involves emotional distress or "perturbation."⁸ By this definition, disabled people's requests to die are, indeed,

⁶Mary Johnson, *Suicide: Lessons, Disabilities*, *RAC*, Jan./Feb. 1991, at 25; 27 (quoting Judge Edward H. Johnson).

⁷EDWIN S. SHNEIDMAN, *UNDERSTANDING SUICIDE* 203 (1985).

⁸J. S. OHO, *The Third Wave, in WHAT WE KNOW ABOUT SUICIDE: BEHAVIOR AND HOW TO TREAT IT* 77-84 (S. Lerner, ed., 1988); K. Siegel, *Psychological Aspects of Rational Suicide*, 40 *AM J PSYCHIATRY* 405-418 (1986); SHNEIDMAN *supra* note 7, at 208.

People with disabilities compose a minority group for which little research data have been collected. A great deal is known, however, about the prevalent social oppression endured by this population. In employment, interpersonal acceptance, economic stability, freedom of mobility, and community access—all variables thought to have a significant bearing on suicide potential—people with disabilities are among the most disadvantaged.¹ Moreover, current research indicates people with disabilities experience more environmentally induced depression than average,² again suggesting an increased potential for preventable suicide.

Ironically, this population, on whose behalf so little suicide research has been conducted, is subject to a burgeoning number of legal and medical decisions concerning the management of intentions to die. Critical life and death precedents and policies are being established at alarming speed, with little concern for the facts and gaps existing in our understanding of disability and suicide.

Often in psychology, the precursor to sound research documentation is careful clinical observation. In the area of disability and suicide, I have endeavored to make such observations on the basis of specialized training and practice in psychological crisis-intervention (including suicide treatment), thousands of therapy hours working with disabled people in rehabilitation and individual practice, and more than three decades of personal experience living in the world as a disabled person actively involved with other people with disabilities.

Over the years of my "continuing education" and clinical experience with disabled individuals, I have heard their problems, fears, needs, and desires with growing force and clarity. At the same time, I have become increasingly concerned by the dearth of resources available to support their impressive efforts to pursue a good life in a frustrating, unwelcoming environment. Particularly alarming is the current trend to deny basic suicide prevention services to individuals who are severely disabled, those most exposed to high risk factors.

Identification

The discriminatory treatment of disabled people who express a desire to die begins with the initial interpretation and labeling of that desire. When a nondisabled person reveals a desire to die, ordinarily it is categorized as "suicidal," and the individual is treated accordingly. For persons with severe disabilities, however—particularly persons who use a respirator, feeding assistance, or other life aids—the desire to die

¹Michael Kahn, *Disability, Policy, and the Problem of Discrimination*, 28 *AM J ORTHOP* 293-308 (1985).

²R. Joy Turner & Morton Besser, *Major Depression and Depressive Symptomatology Among the Physically Disabled*, 178 *J NERVOUS & MENTAL DIS* 345-46 (1990).

rejection and devaluation of disability. More vulnerable, at such points, to the negative regard they sustain on a daily basis, they express the depression as a global disdain for the disabled self. Any features of the individual's life that represent disability or "abnormality," e.g., life aids, become intolerable.

For some persons with disabilities, the distress they express regarding life aids is particularly misleading because it is expressed in the service of a secondary goal. This occurs when an individual seeks discontinuance of life aids as a *means* of suicide precisely because it is likely, those days, to elicit a cooperative response from the environment. For example, if I am a respirator user and I have decided to commit suicide because of a romantic breakup, it would make strategic sense for me to convince others that I can no longer tolerate the respirator. They might not support my death over a romantic loss, but they might accept it—even assist in it—if I present it as an escape from disability. If I receive approval or assistance to commit suicide, not only is the result guaranteed, but I am also relieved of the usual tension of sole responsibility for making the decision and implementing it. People with severe disabilities characteristically are master survivalists. They learn by necessity how to influence others to assist them. It is an essential, creative skill that, unfortunately, can also be applied consciously or unconsciously for self-destruction.

In the special matter of requests by institutionalized disabled persons for discontinuance of life aids, an element of self-destructive anger may be operating that is dangerously overlooked.¹² The underlying psycho-logic of such requests may be: "If people won't help me live my life the way I wish, at least I'll make them help me die." When disability activists and other supportive individuals intervened to prevent quadriplegic Larry McAlice's death, for example, it released his considerable anger towards people and policies responsible for his institutionalization.¹³

¹²Paul G. Quenou, "Suicide: The Fearful Decision," *Psychiatry*, 41 (1967), 1. *Abandon ou refus thérapeutique: signe de passage d'un stade à un autre*, *Revue de la psychiatrie*, 31 (1966), 100-110. *Un suicide à l'hôpital*, *Revue de la psychiatrie*, 31 (1966), 100-110.

¹³Larry McAlice touched off a public controversy in 1969 when he filed for judicial permission to have his ventilator disconnected to cause his death. He had been injured by a motorcycle accident and as a result had lost the use of his arms and legs. He required constant care. Eventually, the Georgia Supreme Court affirmed his right to refuse ventilation. See *State v. McAlice*, 95 S.E. 2d 651 (Ga., 1969). See also Peter Applebaum, *Judge Rules: Quadriplegia Can Be Allowed to End Life* (N.Y. Times, Sept. 7, 1969, at B1 (nat'l ed.)). During, and after the court proceedings, McAlice befriended and then was assisted by numerous individuals to obtain job training, and secure independent living outside the nursing home environment. These developments persuaded McAlice to reverse his decision to die and instead continue to live. See Peter Applebaum, *An Incurable Man Fights to Live* (The New York Times, Feb. 7, 1969, at A1 (nat'l ed.)).

suicidal. Furthermore, they are emotional. While some suicides seem to make more sense to us than others, none is exclusively based on reason without an element of untidy, irrational, human distress.

It is impossible to appreciate the suicidal aspect of many right to die cases unless one understands not only suicide but the realities of living with a disability. The fact is, with sufficient time and support, people generally adjust to disabilities. People of all kinds buck social prejudice regarding disability and gradually change their perspectives on quality of life. They learn to use human and technological assistance to enhance life, integrating the use of such things as respirators, attendant services, urinary devices, and assisted feeding—all referred to in this article as life aids—into their daily routines as gracefully as many people have adjusted to their need for computers and fax machines. Social attitudes notwithstanding, people with disabilities generally feel neither heroic nor tragic because they use life aids. They view such assistance as a mundane aspect of their life-style.

When an individual with disabilities expresses intolerance of life aids or living with a disability, then, it is symptomatic. Such distress may arise from a variety of factors. Often it represents an unresolved adjustment reaction to either a new disability or a change in an existing disability. With appropriate support, information, and time, the distress usually diminishes.

Other times, the distress signals underlying emotional illness, particularly acute or chronic depression. People who struggle to survive in a thwarting environment occasionally despair or "burn out." Before assisted suicide for people with disabilities became popular, severely disabled Lynn Thompson carefully engineered her own death after learning she would lose her independent living funding. Her recorded message left no doubts about the cause of her despair. The threatened cut in her support funds was, she said, "the straw that broke the camel's back."¹⁴

For people with disabilities, as for anyone else, bouts of depression may lead to suicidal impulses. Depression and psychopathology of long standing may also be expressed indirectly in somatic complaints, including complaints about disability. Research on depression indicates a tendency in troubled individuals toward global negative thinking and "internalization." For people with disabilities, this suggests that when depressed for any reason, they are more likely to "internalize" society's

¹⁴R. Stenshaug, "Severely Disabled People Assess the Quality of Their Lives," 17 *Journal of Mental Retardation* 87-91 (1986).

¹⁵George M. Lundberg, "The Role of the Family in the Relationship to Disability and the Role of the Family in the Relationship to Disability," *Journal of Mental Retardation* 87-91 (1986).

hospital, anorexic and seeking narcotics. Her verbalizations focused narrowly on somatic complaints and death. She had a plan to bring about her death. She made demands for support and care from the hospital staff. She said she was unable to feed herself, a fact that people who know her disputed. In sum, she presented more than the necessary number of signs to qualify for a diagnosis of depression with suicide risk of moderate lethality. Yet, several professionals pronounced her free of disorder and labeled her plan reasonable.¹⁵

In an interview videotaped before his death from respirator disconnection, David Rivlin, a man with quadriplegia, presented classic symptoms of depression.¹⁶ He was tearful, his speech slow and flat, his affect consistently depressed. He talked about being sad and fearful. He expressed anger at society for its attitudes toward people with disabilities. He said he could no longer tolerate life in an institution and asked the public to "reach out to others before they lose hope." Records indicate that Mr. Rivlin had been increasingly isolated in his last year and that he had withdrawn from past interests.¹⁷ He indicated reluctance to die but said he saw no alternative. In the face of this evidence, it is difficult to imagine how mental health professionals could have overlooked his depression and suicide potential. Mr. Rivlin died with the assistance of a physician he barely knew following a farewell party in which he saw friends and family who had failed to visit him for years.¹⁸ The assisting physician lauded his death as "a beautiful event" and "good medicine."¹⁹

¹⁵Stanley S. Herr et al., *No Place in Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities*, 8 *Issues in Law & Med.* 3, 9 (1992).

¹⁶*The Life of David Rivlin* (WDDV, Detroit, television broadcast, Aug. 6, 1989).

¹⁷*Id.* at 58.

¹⁸Before his death, Rivlin had sought judicial approval to have his life support withdrawn. Petition for Removal of Life-Sustaining Apparatus and Incidental Relief. In re Rivlin (Mich. Cir. Ct. 1989) (No. 89-94964). In an oral ruling, however, Judge Hilda R. Gage of the Michigan Circuit Court of Oakland County held that the court lacked subject matter jurisdiction because Rivlin's petition was unopposed and the case failed therefore to present a justiciable controversy. The court would not issue a declaratory judgment unless the petitioner amended his petition to plead an actual dispute. Rivlin declined to do so. Apparently, the court was of the opinion that Rivlin's case was not a right to die action but a right to refuse medical treatment action. Thus, no court order was issued approving or restricting the intended refusal. See Letter from Bruce Bracket, Law Clerk for Judge Hilda R. Gage, to Theresa Kealy, Staff Counsel, National Legal Center for the Medically Dependent & Disabled, Inc. (Sept. 27, 1989) (characterizing oral ruling issued from bench by Judge Gage (on file with the National Legal Center litigation office)).

¹⁹Statements made by John W. Fin, M.D. (WMAJ, Detroit radio broadcast, Mar. 2, 1990) (direct quote from broadcast), and *The Life of David Rivlin*, supra note 16 (direct quote from broadcast).

The point is, whether a nonterminal disabled person's request to discontinue life aids results from a disability adjustment crisis, an internalized rejection of the disabled self during depression, anger turned inward, or solely an attempt to solicit environmental assistance in performing the suicidal act, such requests are clearly pathological and forming the suicidal. To view them otherwise is to deny the dignity and value of ordinary life with disability and those who live it.

Disability and Suicide in Clinical Practice

The tendency on the part of the public and the legal system to deny the suicidal intent of disabled persons requesting death assistance could justly be attributed to lack of information. It is more difficult to comprehend this behavior in medical and mental health professionals. Yet in publicized right to die cases involving disabled people, medical experts have been guilty of a striking denial of suicide risk and depressive disorder in the face of significant evidence of psychopathology.

According to the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM-III-R), a major depressive episode is characterized by depressed mood, a loss of interest in usual activities, or both. For definitive diagnosis, there must be a significant number of symptoms from a list that includes appetite disturbance, sleep disturbance, psychomotor agitation or retardation, loss of energy, feelings of worthlessness, difficulty thinking or concentrating, and thoughts of dying. Additional features may include withdrawal from friends and family, self or slowed speech, guilt, suicide attempts, panic attacks, preoccupation with physical problems, irritability, antisocial behavior, and abuse of drugs or alcohol. The average onset is in early adulthood. There is interference in social and occupational functioning; in severe cases the individual may be incapable of self-feeding, dressing, and personal hygiene. Psychosocial stressors, such as the death of a loved one, marital separation, and childbirth, can precipitate a major depressive episode. The manual alerts practitioners to suicide as the most serious complication in this disorder.²⁰

A brief review of two famous cases exemplifies how professionals sometimes abandon medical diagnostic guidelines, such as those just described, when confronted with disability. At age twenty-six, Elizabeth Bouvia, a woman with cerebral palsy, expressed the wish to die after a series of severe losses, including a miscarriage and marital separation. Essentially homeless and impoverished, she voluntarily entered the

²⁰AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 210-21 (4th ed. rev. 1987).

Discriminatory Treatment of Suicidal Persons with Disabilities

Suicide treatment involves several activities or strategies that are thought to be crucial steps in helping individuals at risk.²⁰ They can be summarized as follows:

1. Conceptualizing the problem for which the individual has chosen death as the solution
2. Identifying and treating the individual's urgent needs.
3. Offering alternate solutions to break through the individual's constructive thinking
4. Supporting and reinforcing the life preserving side of the suicidal ambivalence.
5. Preventing death.

Examining each step in the treatment process while referring to recent right to die cases will, hopefully, illustrate the problems of discriminatory suicide intervention for people with disabilities.

Conceptualizing the Problem

It is in the identification of the problem, perhaps, where the unequal treatment of people with disabilities is most blatant. In all the public right to die cases involving conscious nonterminal disabled persons, there is scant evidence of anyone looking beyond the obvious, the disability, as the cause of distress. In fact, there has been a tendency to discount readily available clues leading to other suicide precipitants. Dismissed have been predisposing historical factors such as multiple losses, family dysfunction, childhood abuse or neglect, current stresses (e.g., work, finances, housing, romance), alcohol or drug problems, isolation, loss of control over life-style, and low self-regard.

David Rivlin repeatedly expressed despair and anger over his confinement to a nursing facility. He talked about his death as the only avenue to freedom from the imprisonment of institutionalization. Apparently, his signals of distress were in vain. No professional ever identified his institutionalization as the problem to be addressed. No one helped him find a way to live independently with assistance (as many with similar disabilities do) or to live at all. Kenneth Bergstedt stated his problem so clearly that no one

²⁰Spiegelman, *supra* note 7, at 225-26.

could miss it.²¹ Physicians, reporters, and judges all agreed that Bergstedt wanted to die because he was afraid—afraid of losing his ill father, afraid no one would look after his needs.²² No one treated Bergstedt's fear or despair. No professional even suggested helping him accomplish a healthy separation from his father or teaching him the skills of living he needed to survive. Professionals trained to help and heal allowed Kenneth Bergstedt to be suffocated by his father, as it assenting to a primitive right of filicide.

Physicians and mental health practitioners who hastily conclude in such cases that disability itself is the problem violate their most basic responsibility to conduct a thorough examination. They allow personal bias to distort their grasp of the problem, thereby precluding the quality of assessment required for appropriate intervention.

Addressing Needs

Without an accurate view of the problem, it is impossible for helping professionals to guide desperate persons with disabilities in fulfilling critical needs. A person exhausted by the struggle to live in a world of frustrating barriers may need a variety of things, some concrete, others more spiritual: money, equipment, a place to live, an attendant, nurturance, control over life-style, outside stimulation, creative outlets, love, work, or validation of personal worth. However, if permanent disability itself is the only problem acknowledged, the need to escape the disability receives undue emphasis. A therapeutic response that focuses on one impossible need while neglecting all others may be more detrimental than no response at all. It reinforces the individual's own sense of helplessness that life can be fulfilling enough to justify living. Rivlin and McAtee needed a way to conduct their lives outside an institution. Kenneth Bergstedt needed to secure quality attendant services as well as support to cope without his father. Elizabeth Bouvia needed many things, but, perhaps above all, she needed time—time to heal and re-emerge as she had during past crises in her life.

Offering Alternative Solutions

One of the most dangerous aspects of despair is the development

²¹The father of Kenneth Bergstedt, a twenty-two year old person with quadriplegia and dependent on a ventilator, petitioned the Nevada courts for authority to remove his son's ventilator. Though Kenneth died before the case was resolved, the Nevada Supreme Court went on to rule that he had a right to refuse life support and that such action would not constitute suicide, nor assisting suicide if carried out by others. *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990).

²²More Johnson, *Humanized Questions*, Disability Rev., Sept./Oct. 1990, at 19.

can understand my desire. But I hear them silently telling me to do it—that I'm such a mess I shouldn't want to live. People who tell me to shut up make me angry, but at least they don't sanction my death.²⁵

Preventing Death

The most basic policy of suicide prevention is to protect the client from dying. Not only are disabled individuals often denied this protection, increasingly they are given assistance in committing the act. In the *Boutia* case, the ACLU (American Civil Liberties Union) actually intervened to restrain Riverside General Hospital from treating Ms. Bouvia as it would a nondisabled person in similar circumstances.²⁶ In the cases of Rivlin,²⁷ McAfee,²⁸ and Bergstedt,²⁹ courts sanctioned their deaths without even ordering suicide assessment or treatment from professionals qualified to work with disabled clients.

The Signs of Suicide in People with Disabilities

If stereotypes can be surmounted, it is possible to learn the signs—the red flags—of treatable suicidality in people with disabilities. Dynamically, disabled people who are suicidal present a contextual and symptomatic picture much like that of nondisabled people who are suicidal. Contributing historical features, current correlates or hazards, and immediate precipitants are often similar for both groups. The major difference lies in the significance for people with disabilities of social stress factors associated with their minority status, many of which may not be apparent to observers lacking disability sophistication. Any professional working in suicide assessment should learn the predisposing factors and signs of risk for people with disabilities, including the following:

Family History

Neglect or abuse in childhood
Loss of parent through death or divorce
Suicide of a family member

²⁵PHYLIS YORK, *GRIEVING, SORROW, AND THE HEALING*, p. 145 (1989).

²⁶See Diane Chelman, *Withdrawing Life-Sustaining Treatment from People with Severe Disabilities Who Request It: Legal Trends and Considerations*, 8 BOSTON U. L. & M.D. 55 (1992).

²⁷See supra note 18.

²⁸State v. McAfee, 365 S.E.2d 651 (Ga. 1989).

²⁹McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990).

of rigid, constrictive thinking, sometimes referred to as tunneling. When death seems like the only solution, death is likely to follow. Here, the task of the therapist is to present as many alternatives as possible, seeking help and information as needed from family members, agencies, and other professionals.

All too often, however, persons with disabilities are offered few viable alternatives to death. The professionals assigned to help them are frequently as affected by tunnel vision regarding disability as their clients. Unfortunately, most physicians, nurses, psychologists, and even rehabilitation staff know little beyond the medical facts about living day to day with a disability.³¹ Disability and quality living seem antithetical to many. This bias prevents many professionals from realizing they lack the information that their clients deserve. The fatal error, literally, is their failure to consult disability advocates for advice and resource information, thus cutting their clients off from a world of possible solutions.

Silencing with Life

In the management of suicidal ambivalence, people with disabilities have been treated with striking discrimination. Suicide experts explain that in despairing individuals the desire to die and the desire to find life worth living (enter in balanced opposition until something tilts the equilibrium. A central tenet of suicide treatment is that the helping person must ally with the life-desiring side of the dilemma.³² Quite the opposite occurred for Bouvia, Rivlin, McAfee, and Bergstedt. Ambivalence went unrecognized. Doctors, judges, and family members agreed with the self-destructive impulse, calling it "rational," "courageous," and "the solution." Clearly, people with disabilities find the scale of ambivalence heavily weighted on the side of death.

People with disabilities who have been suicidal often tell us how important it was in their recovery to receive unwavering opposition to their death wishes from key people in the environment. "Tough Love" of how she coped with suddenly acquiring quadriplegia, "Tough Love" co-founder Phyllis York describes her battle with initial depression. Her husband and close friends adamantly protested her desire to die. She writes:

People who tell me they understand my wanting to commit suicide are not helpful. They say that they have been in bad places, too, and

³¹PHILIP G. GARDNER, JR., *THE HOPKINS PATIENTS: PHYSICIANS AND THE ETHICS OF KILLING*, 30 KALIF. L. REV. 401 (1990); Carol L. Call, *A New Social Perspective on Disability and Its Implications for Rehabilitation*, in *SOCIAL ETHICAL IMPLICATIONS IN TREATMENT PLANNING*, in *CALIFORNIA JOURNAL OF LAW & MEDICINE* 49-55 (1987).

³²PHYLIS YORK, *GRIEVING, SORROW, AND THE HEALING* (1989).

family dysfunction (including mental illness or substance abuse in a parent)
(childhood separation from family

Personal Dynamics

History of depression
Previous suicide attempts
History of drug or alcohol use
Low frustration tolerance, poor coping skills, masked dependency
Intense need for control, rigidity
Low self-esteem, unstable sense of identity

Stressors, Contributing Factors

Relationship loss or threatened loss (death, separation)
Abusive relationship
Loss of role or self-esteem, failure
Loss of control over life (due to confinement, restriction, domination)
Social isolation
Health problems, physical losses, pain
Work problems
Housing problems
Financial problems
Legal problems
Major life changes (such as moving, childbirth, job change)

Disability-Specific Risk Factors

New disability, changes in existing disability
Difficulties with "the system" (e.g., financial support programs, government agencies, vocational rehabilitation; includes legal problems—many disabled people resort to the concealment or misrepresentation of reported facts in order to obtain adequate funding for health care and independent living; consequently, they live under threat of exposure)
Difficulty obtaining personal assistance services, assistive technology, equipment, and other life aids
Stresses of chronic poverty
Stress of chronic social devaluation, stigma (may be internalized as hatred of the disabled self)

Loss of primary relationships due to the economic and social stresses of disability (e.g., the spouse exhausted by providing personal care when there is insufficient funding for an attendant; the parent who distances himself or herself from a child with a stigmatizing disability)

Loss or threatened loss of independent living, feared loss of self-determination and control of one's own home and life-style (deriving not from the disability itself but from loss of resources)

Institutionalization or hospitalization (this involves the stress of confinement/restriction, loss of privacy, loss of sexual expression, social and sensory isolation, loss of control over life-style, loss of identity, infantilization, loss of own home)³⁰

Discrimination experiences (in work, housing, education, relationships, health care, transportation, community participation, environmental access, recreation, cultural pursuits)

Experiences of disability-related abuse, defamation, hate, violence (people with disabilities experience a significantly higher incidence of abuse than average)³¹

In short, people with disabilities turn to suicide in response to the usual factors, with the addition of risks specific to living with a disability in our culture. There is nothing about any of the signs and factors on this list that renders them untreatable. As far as we know, people with disabilities benefit from appropriate emotional support and suicide intervention as much as any other group.

Recommendations

To address the problem of discrimination in suicide prevention for people with disabilities, the following recommendations are offered. They are not intended to be complete. They are listed in the hope that they will underscore the urgency of this problem and stimulate concern, discussion, and action from other quarters.

Better Scrutiny of Disabled Persons' Intentions to Die

When a person with disabilities wants to die, the most appropriate

³⁰ Emily Dunkhorn's notion of fatalistic suicide may be relevant here. Dunkhorn characterized the act as "suicide deriving from excessive regulation [by others, and exercised by] persons with futures pitilessly blocked and passions violently choked by oppressive discipline." Emily Dunkhorn, *Suicide*, 276 (J.A. Spaulding & G. Simpson trans., 1964).

³¹ C. Gabbidon, *A Survey of State Efforts in Gathering Information on Child Abuse and Neglect in Handicapped Populations*, 10 *CHILD ABUSE & NEGLECT* 116 (1982).

response (and, sadly, these days, the most neglected) is, "Why?" The death request of a person with disabilities should be explored as rigorously and objectively as it would be for anyone else, including the specific reasons behind it and possible solutions. Mental health professionals who work with people in crisis are trained to be meticulous sleuths. They are taught not only to hear their clients' obvious complaints but also to look further in order to uncover latent problems. Unfortunately, this process is commonly abbreviated or bypassed when the client is severely disabled, with dire results.

Millions of people live with disabilities. Disability is no more a sufficient or acceptable reason for wanting to die than romantic failure would be for an adolescent. Both losses may seem, at times, like the end of the world to those who experience them; but if important people in the environment address this sense of hopelessness rather than acquiesce to it, the individual has a fighting chance of mastering despair.

The Evaluation and Treatment of Disabled Persons Who Wish to Die Should Be Conducted by Professionals with Disability Expertise

Standards of practice in mental health enjoin professionals from practicing beyond the limits of their training and experience. Particularly, practitioners are cautioned against treating minority clients before obtaining adequate education regarding their clients' minority cultural experience. This dictum has been egregiously violated in the treatment of people with disabilities. Basic medical training by itself is grossly insufficient for dealing with the daily social/economic/political problems of disability. Professionals with little appreciation of the complexities of the disability life-style mishandle the needs of disabled clients in despair. Disabled people who want to die deserve to be seen by therapists who speak their language and understand their experience.

Persons Reacting to New or Changing Disabilities Should Be Given Sufficient Time and Support for Adjustment

When the suicidal wish derives from a troubled adjustment to disability, it should be treated as aggressively as any other kind of crisis. Suicide prevention should be implemented. Additionally, the support of family, friends, and community organizations should be enlisted for problem-solving to enhance life quality. This may ultimately require education and treatment for the family to correct prejudices that could sabotage the adjustment of the disabled individual.

Persons Experiencing "Disability Burn-out" Should Be Treated for Stress

Disabled individuals who are exhausted by their struggles with economic, social, and structural barriers in the environment need profes-

sion and time to recover. They need guidance to comprehend and rechannel their feelings and an astute counselor who neither downplays their struggle nor shares their temporary loss of hope. They also need to connect with disability advocates to help them through the barriers ahead.

Psychological Disorder Contributing to Suicidality in Persons with Disabilities Should Be Treated

This recommendation may seem too obvious to warrant listing. It should be beyond question that a person with disabilities who is suffering from depression, situational crisis, panic, and other disorders is entitled to the full range of therapeutic interventions as a nondisabled person in distress. However, the personalities and emotional problems of people with disabilities are often overlooked when helpers fixate on their physical status. Equal treatment includes not only suicide prevention and, when needed, psychiatric hospitalization, but also the option of continuing long-term treatment for any remaining disorder or life problems once the crisis phase has passed.

Legal Protections Must Remain in Place

In a society that fears and rejects life with disability, people with disabilities need laws and the courts to safeguard their equal access to suicide prevention. In cases such as Bouvia's and McAfee's, the time delays and argument inherent in the court process itself may have permitted their change of heart. Many right to die proponents argue for the private right of families (with physicians' consultation) to make expedient life and death decisions for incompetent loved ones. This is a misguided position. Any therapist who has worked with disabled people has heard tragic stories of harm inflicted by loving, well-meaning family members making decisions on their behalf. The commonness of such recollections reminds us that loving someone with a disability does not naturally confer insight or even immunity from prejudice. Moreover, society does little to encourage families in their efforts to support the lives of relatives with disabilities. Consequently, families of people with disabilities often function under considerable economic and emotional strain. They are bombarded with dim assessments of potential life quality from others, including the media and the medical professionals who advise them. Unquestionably, the most caring families can make mistakes. Their authority in life and death decisions must remain amenable to the checks and balances of the legal process.

Disability Experts Must Be Involved

The views of many parties—physicians, family members, attor-

neys, religious advocates, politicians, ethicists, civil libertarians, right to die proponents, and journalists—have been well represented in court and in the media when persons with disabilities have asked to die. Less often heard and rarely heeded has been the voice of the disability community. Briefs filed by disability advocacy groups have been virtually unacknowledged in court proceedings. Views of experts who are disabled are rarely sought or recognized by the legal system, medical establishment, or media. One might wonder if people with disabilities have credibility only when asking to die! An extreme example of the neglect of the disability perspective is the Bergstedt case, in which the court sanctioned the death of a conscious, nonterminal adult without even speaking directly with him. He was represented, in part, by a parent in questionable mental health and by a doctor who acknowledged but saw no need to treat Bergstedt's depression.³² Disability advocates were allowed no opportunity to intervene. The only instance in which disability activists and others familiar with disability issues managed to intervene was in the McAfee case. Here the disability perspective dramatically altered the course of events, and a life was saved.

To guarantee nondiscriminatory treatment of disabled persons who are suicidal, right to die proceedings must be informed by disability awareness. No assistance in dying should ever be considered without evaluation and intervention by qualified professionals and advocates who either have personal disability experience or extensive familiarity with disabled people and their life issues. Competency training for professionals should be developed incorporating key contributions and monitoring by disabled professionals, consumers, and advocates. Physicians, allied medical personnel, suicide prevention staff, hotline workers, and psychiatric intake workers should receive such training to sensitize them to the social dynamics of disabled people's despair.

Last Words

For a country that purports to embrace human diversity, citizens with disabilities constitute the acid test. Our integration into American culture would involve radical changes in such concepts as independence, normality, and quality of life. The belief that life with a severe disability, including the use of life aids, is untenable rudely rejects the culture—the customs and ways of living—of people with disabilities. Reminiscent of the days when many people preferred to "be dead than Red," current opinion reflects an overwhelming public preference for

death to disability.³³ Tragically, this sentiment is only too apparent in the lack of suicide prevention services offered to people with disabilities.

As long as society supports suicide prevention services for anyone, it is morally and legally obligated to extend these services to people who are disabled. To accept a suicide is to encourage it. Encouraging the self-destructive urges of persons with disabilities who despair is not merciful or compassionate. It is dangerous for those individuals, for all disabled people as a devalued group, and ultimately for a society founded on equality. Persons with disabilities demonstrate that they value their lives a great deal more than others do.³⁴ Those who give up on life do so only after struggling with the very human pain of unmet needs. Society must not silence those needs by death but by assisting in their fulfillment. That is the authentic compassionate response.

³³Barbara Bratman, *Ruling Prompts Paper Chase to Get Affairs in Order*, *Civ. Trial*, July 6, 1991, 53, at 1.

³⁴N. Weinberg & J. Williams, *How the Physically Disabled Perceive Their Disabilities*, *J. Rehab.*, July 1978, at 31-33.

³²*Alldredge v. Jack A. Jursaky, M.D., Bergstedt v. McKay* (New Dist. Ct. 1990) (No. A20107).

Mr. CANADY. Thank you, Ms. Coleman.
Dr. Klagsbrun.

**STATEMENT OF SAMUEL C. KLAGSBRUN, M.D., EXECUTIVE
MEDICAL DIRECTOR, FOUR WINDS HOSPITAL**

Dr. KLAGSBRUN. My journey to this table is an odd one, I suppose. In a previous incarnation I am a graduate of the Jewish Theological Seminary, which does not suggest that they adhere to my position. I am a psychiatrist who began working 30 years ago with patients with cancer, and that journey has led me to hospice work as well as to work with suicidal patients. I have spent the last 25 years teaching one week a year at St. Christopher's Hospice in London, which is for this kind of work.

Dame Cicely Saunders, the founder of St. Christopher's, does not support my view or position. So I want to absolve all of those people with whom I work of any sense of responsibility for my position.

I have come to this position from an earlier one which stated that I felt, in the privacy of the sickroom, that a patient and his or her physician had the right to behave and to make whatever appropriate decisions they came to quietly and privately as, in fact, has been done realistically for centuries.

As medical care in America has changed and the climate is changing, I have shifted my position to the present one over the course of years now. I am concerned about physicians practicing medicine increasingly in a more defensive fashion, meaning that they are now looking over their shoulders at hospital administrators, at quality assurance committees, at lawyers, who tend not to feel that the patient's pain and suffering is primary but tend to approach this subject from the point of view of protecting the hospital institution and the doctors.

I don't think that is a proper climate in which to practice medicine. I think the fear of malpractice suits has caused doctors to stop listening to their own patients as well as they used to.

I also feel that the climate that I have just described has resulted in something, along with economic factors, which influence medical care these days in the country, and that is that patients who are very sick, terminally ill, suffering greatly, end up being passed on to other levels of care, nursing homes, newer doctors, and hopefully at times hospices. So patients at a terrible time in their lives are being abandoned, I think, unnecessarily and sadly.

Finally, I will offer my own personal experience at the bedside of patients. Though I am a psychiatrist, I spend a lot of time with cancer patients, dealing with their emotional well-being.

Just to give you an example, my aunt, my father's sister, is 87 years old. A few years ago, she slipped into a major depression. There was nothing physically wrong with her. She is a classic product of a doting family and has lived a charmed life—attractive, interesting, terribly, terribly European and vain beyond words. Actually, she was always a very difficult woman to be with.

She asked me, recognizing a slipping of the quality of her life, which, to her, by the way, was defined as really not being able to go shopping anymore—that was the quality of life criteria that she used—and she begged me and said, "Sam, please, when the time comes, if I need help in dying, will you promise to do so?" I said

to her over the course of many conversations, "I really have to stick to my criteria, not yours, for participating in something like this, and I don't think you want to accept my criteria."

We negotiated back and forth. My purpose in the discussion, was to keep her going and to argue for the next 20 years. Finally she agreed to my terms, at which point I said to her that I would help her die. It is now 3 years later. She was about 84 at that time.

She has now slipped into an Alzheimer's state of being. She no longer recognizes me. The issue is not relevant, it is not pertinent, and I certainly have not and will not participate in helping her die. She is not a competent person.

But what did happen—and this is my point—my aunt, when I finally said, yes, heaved a sigh of relief, wept with gratitude, said thank you, and went back to her life with energy, interest, and continued spending much more money than she should have, shopping. Her depression, in that sense, was relieved.

The point I want to make is that there are a number of patients for whom major suffering is due to severe pain treated in a hospice care setting, who still, as Dr. Quill indicated, end up being beyond our competence to help. We need to help them negotiate the last phase of life with decent and reasonable comfort. That patient population needs to feel that we will listen, we will hear their plea, and we will help them.

I want to end with the following, four criteria that I use for myself, which makes a difference between permitting myself to help someone die and not doing so. And the reason for those four criteria—and there are many others—is, as Dr. Quill said before, the need to focus on safeguards. We need to make sure this is not an open-ended, slippery slope situation, which I agree we need to be concerned about.

My four criteria are not easy to come by. They require a physician and a competent patient to know each other quite well. The physician must know the family, their value system, and ethical system of the family and the patient. They must really know each other. The physician must not come in like a swooping angel of death after a 1-hour consultation and do the deed. I think that is obscene.

The second criteria is that the physician must be assured that properly controlled pain management has been made available and has failed.

The third criteria: The physician must be assured that we are not treating a patient's depression in the form of a request to die; that the patient, if a patient is depressed, has been properly and adequately treated for depression so that it is not the relevant factor.

And the fourth one comes from my prior life experience I feel that life is sacred. It needs to be fought for, and therefore the physician, in struggling with this issue, must suffer. The physician has to be the kind of person who is very uncomfortable in participating in an act like this and hopefully will always feel uncomfortable and in pain, facing this moment with great difficulty.

And my final sentence is that when my time comes, I sincerely hope that Kathy Foley will be in good shape, alive, and well, because I do want her to take care of me.

[The prepared statement of Dr. Klagsbrun follows:]

PREPARED STATEMENT OF SAMUEL C. KLAGSBRUN, M.D., EXECUTIVE MEDICAL
DIRECTOR, FOUR WINDS HOSPITAL

A patient who asks to die is invariably a tragedy be they old or young. My very sick father-in-law who is 100 years old and fully competent mentally, is a prisoner of a very sick body. He is adamantly interested in living every moment of his life and has said to me only recently, "Sam, better one hour above the ground than an eternity under the ground."

My fundamental belief is that life is sacred and having to help bring life to an end ought to be done only after a prolonged struggle. We need to develop proper safeguards for this process not to be abused.

Physicians in the privacy of the consultation room and at the bedside have for centuries participated actively in helping patients die quietly and privately. The secrecy of this behavior has often left physician's feeling extremely uncomfortable and inclined to pass difficult pain-racked patients on to nursing homes or new physicians who are essentially strangers to the patients. To be passed on or abandoned at that stage in life is cruel and unnecessary.

I am, of course, fully aware as we all are of the potential of abuse of this ruling. As an attempt to define safeguards to prevent abuse of this ruling, I offer the following four criteria: 1. A physician and a patient must know each other over a long period of time so that the physician may understand the patient's values, lifestyle and family relationships in order to understand the request to die properly. 2. A physician must be assured that sophisticated symptom control has been given every chance to relieve the suffering of the patient. 3. The patient's request to die must not be an expression of a treatable depression. 4. A physician needs to go through an internal struggle and never get to the point of being comfortable with such a decision.

Mr. CANADY. Thank you, Doctor.
Dr. Hendin.

**STATEMENT OF HERBERT HENDIN, M.D., EXECUTIVE
DIRECTOR, AMERICAN SUICIDE FOUNDATION**

Dr. HENDIN. Thank you.

Most people assume that seriously or terminally ill people that wish to end their lives are different than those who are otherwise suicidal. But the first reaction of many patients to the diagnosis of serious illness and possible death is terror, depression, and a wish to die. Such patients are not significantly different than patients who react to other crises in their lives with the desire to end the crisis by ending their lives.

Suicidal patients are also prone to make conditions on life: I won't live without my husband if I lose my looks, power, prestige, or health, or if I am going to die soon. They are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and circumstances of their death is the most dramatic expression of their need for control. The request for assisted suicide is also usually made with as much ambivalence as are most suicide attempts.

If the doctor doesn't recognize the ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror.

I have just completed a study of assisted suicide and euthanasia in the Netherlands, where both are accepted practices. In the past decade, by making assisted suicide and euthanasia easily available to those over 50, the Dutch have reduced the suicide rate in this segment of their population.

Among an older population, physical illness of all types is common and many who have trouble coping with physical illness become suicidal. In a culture accepting of euthanasia, their distress is accepted as a good reason for dying. It may be more than ironic to describe euthanasia as the Dutch cure for suicide.

Should we consider legalization of assisted suicide an extension of the patients' rights movement? That it is often the doctor and not the patient who determines the choice for death was underlined by the documentation of involuntary euthanasia in the Rummelink report, the Dutch Government's commissioned study of the problem.

The report revealed that in over 1,000 cases, of the 130,000 deaths in the Netherlands each year, physicians admitted they actively caused or hastened death without any request from the patients. In about 5,000 cases, physicians made decisions that might or were intended to end the lives of competent patients without consulting them. I was given as an example of a case where this was necessary, a doctor who terminated the life of a nun who was dying in great pain but whose religious convictions did not permit her to ask for death.

Even when the patient requests or consents to euthanasia, in cases presented to me in the Netherlands and cases I have reviewed in this country, assisted suicide and euthanasia were usually the result of an interaction in which the needs and character

of family, friends, and doctor play as big, and often bigger, role than those of the patient.

A study of euthanasia done in Dutch hospitals concluded that in most cases families, doctors, and nurses were involved in pressuring patients to request euthanasia.

A Dutch medical journal described a wife who no longer wished to care for her sick husband. She gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to be killed. The doctor, though aware of the coercion, ended the man's life.

The Rummelink report revealed that more than half of Dutch physicians considered it appropriate to introduce the subject of euthanasia to their patients. They seemed not to recognize that the doctor was also telling the patient that his or her life was not worth living, a message that would have a powerful effect on the patient's outlook and decision.

Social sanction in the Netherlands has encouraged patients and doctors to see assisted suicide and euthanasia, intended as an unfortunate necessity in exceptional cases, as almost a routine way of dealing with serious or terminal illness.

The public has the illusion that legalizing assisted suicide and euthanasia will give them greater autonomy. If the Dutch experience teaches us anything, it is that euthanasia enhances the power and control of doctors who can suggest it, not give patients obvious alternatives, ignore patients' ambivalence, and even put to death patients who have not requested it.

[The prepared statement of Dr. Hendin follows:]

PREPARED STATEMENT OF HERBERT HENDIN, M.D., EXECUTIVE DIRECTOR, AMERICAN
SUICIDE FOUNDATION

Does our need to care for people who are terminally ill and to reduce their suffering require us to give physicians the right to end patients' lives?

Asking this question helps make us aware that neither legalizing nor forbidding physician-assisted suicide or euthanasia addresses the much larger problem of providing humane care for those who are terminally ill. To some degree the call for legalization is a symptom of our failure to develop a better response to the problems of dying and the fear of unbearable pain or artificial prolongation of life in intolerable circumstances.

The uninitiated are apt to assume that the seriously or terminally ill who wish to end their lives are different than those who are otherwise suicidal. The first reaction of many patients to the knowledge of serious illness and possible death, however, is terror, depression, and a wish to die. Such patients are not significantly different than patients who react to other crises in their lives with the desire to end the crisis by ending their lives.¹

Many patients and physicians displace anxieties about death onto the circumstances of dying: pain, dependence, loss of dignity, and the unpleasant side effects of medical treatments. Focusing on or becoming enraged at the process distracts from the fear of death itself.

Suicidal patients are also prone to make conditions on life:

I won't live ... "without my husband," ... "if I lose my looks, power, prestige or health," or "if I am going to die soon." They are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and circumstances of their death is the most dramatic expression of their need for control.

Depression, often precipitated by discovering a serious illness, exaggerates the tendency toward seeing problems in black-or-white terms. When a patient finds a doctor who shares the view that life is only worth living if certain conditions are met, the patient's rigidity is reinforced.²

Patients are not alone in their inability to tolerate situations they cannot control. From the physician's viewpoint, Lewis Thomas has written insightfully about the sense of failure and helplessness that doctors may experience in the face of death;³ such feelings might explain why doctors have such difficulty discussing terminal illness with patients. A majority of doctors avoid such discussions, while most patients would prefer frank talk.⁴ These feelings might also explain both doctors' tendency to use excessive measures to maintain life and their need to make death a physician's decision. By deciding when patients die, by making death a medical decision, the physician preserves the illusion of mastery over the disease and the accompanying feelings of helplessness. The physician, not the illness, is responsible for the death. Assisting suicide

and providing euthanasia become ways of dealing with the frustration of being unable to cure the disease.

The request for assisted suicide is also usually made with as much ambivalence as are most suicide attempts. If the doctor does not recognize that ambivalence as well as the anxiety and depression that underlie the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror.⁵

A few years ago, a young professional in his early thirties who had acute myelocytic leukemia was referred to me for consultation. With medical treatment, Tim was given a 25 percent chance of survival; without it, he was told, he would die in a few months.

Tim, an ambitious executive whose focus on career success had led him to neglect his relationships with his wife and family, was stunned. His immediate reaction was a desperate, angry preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease and the side effects of treatment.

Tim's anxieties about the painful circumstances that would surround his death were not irrational, but all his fears about dying amplified them. Once Tim and I could talk about the possibility or likelihood of his dying--what separation from his family and the destruction of his body meant to him--his desperation subsided. He accepted medical treatment and used the

remaining months of his life to become closer to his wife and parents. Two days before he died, Tim talked about what he would have missed without the opportunity for a loving parting.⁶

If assisted suicide were legal, as an Oregon law now being contested in the courts would make it, Tim probably would have asked a doctor's help in taking his own life. Because he was mentally competent, he would have qualified for assisted suicide and would surely have found a doctor who would have agreed to his request.

I have just completed a study of assisted suicide and euthanasia in the Netherlands where both are accepted practice. Early in my work, in a film, Appointment with Death,⁷ intended to promote euthanasia that I was shown by the Dutch Voluntary Euthanasia Society, I was reminded of Tim by seeing an example of how a physician's failure to deal with a patient's fear of death led to a premature ending of the patient's life.

A forty-two year old man was diagnosed as HIV positive. He had no physical symptoms, but had seen others suffer with them and wanted his physician's assistance in dying. The doctor compassionately explained to him that he might live for some years symptom-free.

Over time the patient repeated his request for euthanasia and eventually his doctor acceded to it. The man was clearly depressed and overwhelmed by the news of his situation. The doctor kept establishing that the patient was persistent in his request and competent to make the decision - criteria a Dutch

patient must meet - but did not address the terror that underlay it.

Consultation in the case was pro forma. A colleague of the doctor's saw the patient briefly to confirm his wishes. In many cases the consultant does not see the patient at all. With a psychologically sensitive physicians looking for more than justification to respond to the request to die, more likely in a culture not so accepting of euthanasia, this man would not have needed to be put to death.

In the cases presented to me by physicians in the Netherlands, and in cases I have reviewed in this country, I saw such examples many times over. Patients whose fear of death precipitates them into seeking assisted suicide or euthanasia may be quite different than those who are concerned that they may suffer unduly in the last days of their lives.

Whenever, as in the Netherlands, or in the recent Oregon law now under challenge in the courts, there is legal sanction for assisted suicide for patients who are not in the last weeks of their lives, the two groups of patients become hopelessly confused. In such a situation basically suicidal patients become the willing victims of euthanasia practitioners.

In the past decade by making assisted suicide and euthanasia easily available, the Dutch have significantly reduced the suicide rate of those over fifty in the population.⁸ The likelihood that patients would end their own lives if euthanasia was not available to them was one of the justifications given by

Dutch doctors for providing such help.

Of course, euthanasia advocates can maintain that making suicide "unnecessary" for those over fifty who are physically ill is a benefit of legalization rather than a sign of abuse. Such an attitude depends, of course, on whether one believes that there are alternatives to assisted suicide or euthanasia for dealing with the problems of older people who become ill.

Among an older population physical illness of all types is common, and many who have trouble coping with physical illness become suicidal. In a culture accepting of euthanasia their distress may be accepted as a legitimate reason for euthanasia. It may be more than ironic to describe euthanasia as the Dutch cure for suicide.

That seems even more true since the Dutch have recently accepted mental suffering without physical illness as justification for assisted suicide and euthanasia. How this acceptance translates into practice with a psychiatric patient is evident in a case that has received a good deal of international attention since it was the case that formally established in the Netherlands that mental suffering was sufficient justification for assisted suicide.

In the spring of 1993 a Dutch court in Assen ruled that a psychiatrist was justified in assisting in the suicide of his patient, a physically healthy but grief-stricken 50-year-old social worker who was mourning the death of her son and who came to the psychiatrist saying she wanted death, not treatment. I had

a chance to spend about seven hours interviewing the psychiatrist involved. Without going into the details of the case which I have discussed elsewhere,⁹ it is worth noting that the psychiatrist assisted in the patient's suicide a little over two months after she came to see him, about four months after her younger son died of cancer at 20. Discussion of the case centered around whether the psychiatrist, supported by experts, was right in his contention that the woman suffered from an understandable and untreatable grief. Although no one should underestimate the grief of a mother who has lost a beloved child, life offers ways to cope with such grief and time alone was likely to have altered her mood.

The Dutch Supreme Court which ruled on the Assen Case in June 1994 agreed with the lower courts in affirming that mental suffering can be grounds for euthanasia, but felt that in the absence of physical illness a psychiatric consultant should have actually seen the patient. Since it felt that in all other regards the psychiatrist had behaved responsibly it imposed no punishment. Since the consultation can easily be obtained from a sympathetic colleague, it offers the patient little protection. The case was seen as a triumph by euthanasia advocates since it legally established mental suffering as a basis for euthanasia.

Over the past two decades, the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from

euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to nonvoluntary and involuntary euthanasia.

Once the Dutch accepted assisted suicide it was not possible legally or morally to deny more active medical help i.e. euthanasia to those who could not effect their own deaths. Nor could they deny assisted suicide or euthanasia to the chronically ill who have longer to suffer than the terminally ill or to those who have psychological pain not associated with physical disease. To do so would be a form of discrimination. Involuntary euthanasia has been justified as necessitated by the need to make decisions for patients not competent to choose for themselves.

That it is often the doctor and not the patient who determines the choice for death was underlined by the documentation of "involuntary euthanasia" in the Rummelink report - the Dutch government's commissioned study of the problem.¹⁰ "Involuntary euthanasia" is a term that is disturbing to the Dutch. The Dutch define euthanasia as the ending of the life of one person by another at the first person's request. If life is ended without request they do not consider it to be euthanasia. The Rummelink report uses the equally troubling expression "termination of the patient without explicit request" to refer to euthanasia performed without consent on competent, partially competent, and incompetent patients.

The report revealed that in over 1,000 cases, of the 130,000

deaths in the Netherlands each year, physicians admitted they actively caused or hastened death without any request from the patient. In about 25,000 cases, medical decisions were made at the end of life that might or were intended to end the life of the patient without consulting the patient. In nearly 20,000 of these cases (about 80 percent) physicians gave the patient's impaired ability to communicate as their justification for not seeking consent.

This left about 5,000 cases in which physicians made decisions that might or were intended to end the lives of competent patients without consulting them. In 13 percent of these cases, physicians who did not communicate with competent patients concerning decisions that might or were intended to end their lives gave as a reason for not doing so that they had previously had some discussion of the subject with the patient. Yet it seems incomprehensible that a physician would terminate the life of a competent patient on the basis of some prior discussion without checking if the patient still felt the same way.

A number of Dutch euthanasia advocates have admitted that practicing euthanasia with legal sanction has encouraged doctors to feel that they can make life or death decisions without consulting patients. Many advocates privately defend the need for doctors to end the lives of competent patients without discussion with them. An attorney who represents the Dutch Voluntary Euthanasia Society gave me as an example a case in

which a doctor had terminated the life of a nun a few days before she would have died because she was in excruciating pain but her religious convictions did not permit her to ask for death. He did not argue when I asked why she should not have been permitted to die in the way she wanted.

Even when the patient requests or consents to euthanasia, in cases presented to me in the Netherlands and cases I have reviewed in this country, assisted suicide and euthanasia were usually the result of an interaction in which the needs and character of family, friends, and doctor play as big and often bigger role than those of the patient.

In a study of euthanasia done in Dutch hospitals, doctors and nurses reported that more requests for euthanasia came from families than from patients themselves. The investigator concluded that the families, the doctors, and the nurses were involved in pressuring patients to request euthanasia.¹¹

A Dutch medical journal noted an example of a wife who no longer wished to care for her sick husband; she gave him a choice between euthanasia and admission to a home for the chronically ill. The man, afraid of being left to the mercy of strangers in an unfamiliar place, chose to be killed. The doctor, although aware of the coercion, ended the man's life.¹²

The Rummelink report revealed that more than half of Dutch physicians considered it appropriate to introduce the subject of euthanasia to their patients. Virtually all the medical advocates of euthanasia that I spoke to in the Netherlands saw

this as enabling the patient to consider an option that he or she may have felt inhibited about bringing up, rather than a form of coercion. They seemed not to recognize that the doctor was also telling the patient that his or her life was not worth living, a message that would have a powerful effect on the patient's outlook and decision.

The Dutch experience illustrates how social sanction promotes a culture that transforms suicide into assisted suicide and euthanasia and encourages patients and doctors to see assisted suicide and euthanasia--intended as an unfortunate necessity in exceptional cases--as almost a routine way of dealing with serious or terminal illness.

Pressure for improved palliative care appears to have evaporated in the Netherlands. Discussion of care for the terminally ill is dominated by how and when to extend assisted suicide and euthanasia to increasing groups of patients. Given the inequities in our own health care system and the inadequacies of our care of those who are terminally ill, palliative care would be an even more likely casualty of euthanasia in this country. Euthanasia will become a way for all of us to ignore the genuine needs of terminally ill people.

The public has the illusion that legalizing assisted suicide and euthanasia will give them greater autonomy. If the Dutch experience teaches us anything it is that the reverse is true. In practice it is still the doctor who decides whether to perform

euthanasia. He can suggest it, not give patients obvious alternatives, ignore patients' ambivalence, and even put to death patients who have not requested it. Euthanasia enhances the power and control of doctors, not patients.

People assume that the doctor encouraging or supporting assisted suicide is making as objective a judgment as a radiologist reading an x-ray. The decisive role of the physician's needs and values in the decision for euthanasia are not apparent to them.

Virtually every guideline set up by the Dutch to regulate euthanasia has been modified or violated with impunity. Despite their best efforts, the Dutch have been able to get only 60 percent of their doctors to report their euthanasia cases (and there is reason from the Rummelink Report to question whether all of them are reporting truthfully). Since following the legal guidelines would free from the risk of prosecution the 40 percent of Dutch doctors who admit to not reporting their cases and the 20 percent who say that under no circumstances will they do so, it is a reasonable assumption that these doctors are not following the guidelines. The cases presented to me and to Dr. Carlos Gomez bear this out. Dr. Gomez and I went to the Netherlands at different times and with totally different perspectives, since he is a palliative care specialist and I am a psychiatrist. Yet after hearing detailed cases of euthanasia presented by Dutch physicians, we independently came to the same conclusion: that it is not possible to sanction and regulate

euthanasia within any prescribed guidelines.¹³

A supervisory system intended to protect patients would require an ombudsman to look at the overall situation including the family, the patient, the doctor, and, above all, the interaction among them prior to the performance of assisted suicide or euthanasia. This would involve an intrusion into the relationship between patient and doctor that most patients would not want and most doctors would not accept.

Without such intrusion before the fact, there is no law or set of guidelines that can protect patients. After euthanasia has been performed, since only the patient and the doctor may know the actual facts of the case, and since only the doctor is alive to relate them, any medical, legal, or interdisciplinary review committee will, as in the Netherlands, only know what the doctor chooses to tell them. Legal sanction creates a permissive atmosphere that seems to foster not taking the guidelines too seriously. The notion that those American doctors-- who are admittedly breaking some serious laws in now assisting in a suicide--would follow guidelines if assisted suicide were legalized is not borne out by the Dutch experience; nor is it likely given the failure of American practitioners of assisted suicide to follow elementary safeguards in cases they have published.

Patients who request euthanasia are usually asking in the strongest way they know for mental and physical relief from suffering. When that request is made to a caring, sensitive, and

knowledgeable physician who can address their fear, relieve their suffering, and assure them that he or she will remain with them to the end, most patients no longer want to die and are grateful for the time remaining to them.

Advances in our knowledge of palliative care in the past twenty years make clear that humane care for the terminally ill does not require us to legalize assisted suicide and euthanasia. Study has shown that the more physicians know about palliative care the less apt they are to favor legalizing assisted suicide and euthanasia.¹⁴ Our challenge is to bring that knowledge and that care to all patients who are terminally ill.

Our success in meeting the challenge of providing palliative care for those who are terminally ill will do much to preserve our social humanity. If we do not provide such care, legalization of assisted suicide and euthanasia will become the simplistic answer to the problems of dying. If legalization prevails, we will lose more lives to suicide (although we will call the deaths by a different name) than can be saved by the efforts of the American Suicide Foundation and those of all the other institutions working to prevent suicide in this country.

The tragedy that will befall depressed suicidal patients will be matched by what will happen to terminally ill people, particularly older poor people. Assisted suicide and euthanasia will become routine ways of dealing with serious and terminal illness just as they have in the Netherlands; those without means will be under particular pressure to accept the euthanasia

option. In the process, palliative care will be undercut for everyone.

Euthanasia advocates have come to see suicide as a cure for disease and a way of appropriating death's power over the human capacity for control. They have detoured what could be a constructive effort to manage the final phase of life in more varied and individualistic ways. Our social policy must be based on a larger and more positive concern for people who are terminally ill. It must reflect an expansive determination to relieve their physical pain, to discover the nature of their fears, and to diminish suffering by providing meaningful reassurance of the life that has been lived and is still going on.¹⁵

References

1. H. Hendin, and G. Klerman, "Physician-Assisted Suicide: The Dangers of Legalization," *American Journal of Psychiatry*, 1993
2. H. Hendin, *Suicide in America*, New York: W. W. Norton, 1995.
3. Ibid.
4. L. Thomas, "Dying as Failure?," *American Political Science Review*, 1984,444:1-4.
5. D. Hendin, *Death as a Fact of Life*, New York: W.W. Norton, 1973, citing H. Feifel "Physicians Consider Death," unpublished manuscript presented at 1967 meeting of the American Psychological Association.

6. H. Hendin, "Selling Death and Dignity," Hastings Center Report,
7. An Appointment with Death, K.A. Productions, 1993.
8. H. Hendin, "Assisted Suicide, Euthanasia and Suicide Prevention: The Implications of the Dutch Experience," Suicide and Life-Threatening Behavior, 1995; 25:193-203.
9. H. Hendin, "Seduced by Death: Doctors, Patients and the Dutch Cure," Issues in Law and Medicine, 1994; 10:123-168.
10. P.J. van Der Maas, W. van Delden, and L. Pijnenborg, Euthanasia and Other Medical Decisions Concerning the End of Life, New York: Elsevier, 1992.
11. H.W. Hilhorst, Euthanasie in het Ziekenhuis [Euthanasia in the Hospital,] Lochem: De Tijdstroom, 1983.
12. H. Ten Have and G. Kimsma, Geneeskunde: Tussen Droom en Drama [Medical Science: Between Dream and Drama,] Kampen: R.O.K. Agora, 1985, pp. 83-84.
13. C. Gomez, Regulating Death: Euthanasia and the Case of the Netherlands, New York: The Free Press, 1991.
14. R.K. Portenoy, N. Coyle, K.M. Kash, F. Brescia, C. Scanlon, D. O'Hare, R.I. Misbin, J. Holland, K.M. Foley, "Determinants of the Willingness to Endorse Assisted Suicide: A Survey of Physicians, Nurses and Social Workers," unpublished manuscript, 1995.
15. H. Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure, New York, W. W. Norton, 1996 (October).

Scared To Death Of Dying

By Herbert Hendin

The conflict over legalizing assisted suicide and euthanasia might well tear our society apart. Yet neither legalization nor opposition to it constitutes a public policy that addresses the much larger problem of how to care for the terminally ill.

The call for legalization is a symptom of our failure to develop a better response to death and the fear of intolerable pain or artificial prolongation of life.

The absence of such a policy permits doctors like Jack Kevorkian to be seen as the only champions of the terminally ill and legalization to be perceived as the cure for fear.

A law that Oregon voters approved in November would permit doctors to prescribe lethal drugs to patients judged to be in the last six months of life. The law, under a restraining order pending a hearing Monday on its constitutionality, is the latest example of how public frustration can lead to action that only compounds the problem.

It is not just that it is impossible to predict with certainty that a patient has only six months to live, making mistaken or falsified predictions inevitable. Any law that permits assisted suicide when patients are neither in pain nor imminently about to die will encourage people who fear death to take a quicker way out.

A few years ago, a young professional in his early 30's who had acute myelocytic leukemia was referred to me for consultation. With medical treatment, he was given a 25 percent chance of survival, without it he was told, he would die in a few months.

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His immediate reaction was a desperate preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease and the side effects of treatment. His anxieties about the painful circumstances that would surround his death were not irrational, but all his fears about dying amplified them.

Many patients and physicians displace anxieties about death onto the circumstances of dying — pain, dependence, loss of dignity, the unpleasant side effects resulting from medical treatment. Once the young man and I could talk about the possibility or likelihood of his dying — what separation from his family and the destruction of his body meant to him — his desperation subsided. He accepted medical treatment and used the remaining months of his life to become closer to his wife and parents. Two days before he died, he talked about what he would have missed without the opportunity for a loving parting.

Under the Oregon law, he probably would have asked a doctor's help in taking his own life. Because he was mentally competent and did not meet the clinical criteria for a diagnosis of depression, he would have qualified for assisted suicide and would surely have found a doctor who would agree to his request.

Since the Oregon law, using guidelines like these in effect in the Netherlands, does not require an independently referred doctor for a second opinion, he would have been referred by a physician supportive of assisted suicide to a colleague who was equally supportive. The evaluation would very likely have been positive. He could have been put to death in an unrecognized state of terror, unable to give himself the chance of getting well or of dying in the dignified way he did.

Many of us have known situations in which a doctor would have acted

The terminally ill need better care, not euthanasia.

humanely by helping a terminally ill person die in the final weeks of an illness. Partly because of such experiences, when people are asked, "Are you in favor of euthanasia?" most answer yes.

But if people were asked, "If terminally ill, would you rather be given treatment to make you comfortable or have your life ended by a physician?", their responses might be different. Or consider this question: "If terminally ill, should it be your decision or your doctor's when you should die?"

My observations in the Netherlands persuade me that legalization of assisted suicide and euthanasia is not the answer to the problems of the terminally ill. The Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for the chronically ill, from euthanasia for physical illness to euthanasia for psychological distress and from voluntary euthanasia to involuntary euthanasia (called "termination of the patient without explicit request"). The Dutch Government's own commissioned research has documented that in more than 1,000 cases a year, doctors actively caused or hastened death without the patient's request.

Virtually every guideline established by the Dutch to regulate euthanasia has been modified or violated with impunity. A healthy but grief-stricken social worker mourning the death of her son two months earlier was assisted in suicide. A man in his 30's who is HIV positive but who has no symptoms and may



Alan S. Feder

not develop them for years was also helped to die, without any effort to address the terror behind his desire to end his life.

Euthanasia in the Netherlands — intended as an unfortunate necessity in exceptional cases — has become almost a routine way of dealing with serious or terminal illness, and even with grief. A statute passed last year codifying guidelines provides added protection for doctors — but not for patients.

Yet the dangers threatened by legalization of assisted suicide can be avoided. They are being avoided elsewhere in Western Europe, where there is no great demand for legalizing assisted suicide or euthanasia.

Care for the terminally ill is better in the Scandinavian countries than in the United States and in the Netherlands. Scandinavian doctors do not accept excessive measures for prolonging life in people who are virtually dead, but neither do they encourage people to choose death prematurely.

There is a great deal of evidence that in the United States, as in the Netherlands, doctors are not sufficiently trained in the relief of pain and discomfort in terminally ill patients. We have not yet educated the public about their choices of the end

of life. And we have not devoted enough time in medical schools to educating future physicians about the painful truth that there will be patients they will not be able to save but whose needs they must address.

Dr. Kevorkian and others are using the courts to test the law, and the Michigan Supreme Court ruled this week that the state may impose criminal penalties on those who assist in a suicide.

But we need more than a case-by-case testing or even a ruling by the United States Supreme Court. If we are to address national concerns over how we die, we need a national commission to study the care of the terminally ill — one similar to the Presidential commission that in 1983 produced guidelines on when to withhold life-sustaining treatment from dying patients. Both euthanasia advocates and opponents would participate, but the panel would be primarily concerned with the larger question of the care of the terminally ill. Whatever its conclusions, a commission would educate the medical profession and the public and help us arrive at a consensus. □

Dying of Resentment

By Herbert Hendin

The case of George Delury, the Manhattan editor who encouraged and facilitated the suicide of his wife, Myrna Lebov, explodes a myth. Chronically ill and dependent people who say they want help in committing suicide are not always acting out of free choice. The request can be a way of begging for support.

Mr. Delury pleaded guilty last week to attempted manslaughter; he could be sentenced to six months in prison. But our society should plead guilty as well, because it, too, has abandoned America's Myrna Lebovs and George Delurys.

Mr. Delury's lawyer, Benjamin Brafman, said his client accepted a plea bargain because he feared a jury's reaction to excerpts from his diary.

In excerpts released to the media, Mr. Delury expressed his wish to be relieved of the burden of caring for his 52-year-old wife who was suffering from multiple sclerosis. He wrote, "You are sucking my life out of me like a vampire and nobody cares." It seems that his desire heavily influenced her decision to commit suicide in July by drinking a mixture

of antidepressants, water and honey.

Mr. Delury's despair over the unrelieved drudgery of attending to his wife's bodily functions and emotional needs reflects a widespread desperation among the seriously (but not necessarily terminally) ill and their families.

In the Netherlands, where assisted suicide and euthanasia are common, a 1983 study showed that more requests for euthanasia came from families than from patients. A medi-

When patients ask for assisted suicide, they often don't mean it.

cal journal told of a woman who no longer wished to care for her sick husband. She gave him a choice between euthanasia and admission to a nursing home. Afraid of being left to the mercy of strangers in an unfamiliar place, he chose death. A doctor, although aware of the coercion, ended his life.

My four years of research on assisted suicide and euthanasia, largely in the Netherlands, shows that Dutch doctors called in such cases usually advocate euthanasia. They invariably support the relatives' desire to be free of the burden of caring

for the patient. My work also shows that acceptance of euthanasia in the Netherlands has reduced interest in alleviating pain and suffering; euthanasia becomes an easier alternative — even when a person is not terminally ill.

A patient requesting assisted suicide is often ambivalent. The request may cloak a cry for reassurance that one is loved and valued despite physical decline. If the family and doctor don't wish to listen, the patient may become trapped by the request and feel that he or she has no choice.

A 1989 Swedish study showed that when chronically ill patients attempted suicide, their overburdened families often did not want them resuscitated. But when society stepped in and relieved the family's burden by sending in home care helpers, most patients wanted to live and their families wanted them to live, too.

In America, it is time to provide a solution — affordable home care — that does not pit patients and families against each other. We need to insist that health plans routinely provide home care like nursing, feeding, bathing and companionship. Under Medicaid and Medicare, such help varies by state and should be made more consistently accessible to all.

Mr. DeLury has accepted some responsibility for Myrna Lebov's death. Only when our society accepts its share of responsibility will patients like Ms. Lebov really have a choice. □

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Selling Death and Dignity

by Herbert Hendin

Advocates use case descriptions to show that euthanasia or assisted suicide is sometimes justifiable. Yet even the seemingly clearest cases can prove deeply troubling.

Dying is hard to market. Voters, many repelled by the image of doctors giving their patients lethal injections, rejected euthanasia initiatives

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Herbert Hendin, "Selling Death and Dignity," *Hastings Center Report* 25, no. 3 (1995): 19-23.

in Washington and California. Learning from these defeats, Oregon sponsors of a similar measure limited it to assisted suicide, while still casting the patient in the role familiar from euthanasia advertising: the noble individualist fighting to exercise the right to die.

Although both assisted suicide and euthanasia have been presented as empowering patients by giving them control over their death, assisted suicide has been seen as protecting

against potential medical abuse since the final act is in the patient's hands. Yet opponents see little protection in assisted suicide: people who are helpless or seriously ill are vulnerable to influence or coercion by physicians or relatives who can achieve the same ends with or without direct action. How could advocates counteract not only images of lethal physicians but images of grasping relatives, eager to be rid of a burden or to gain an inheritance by coercing death?

Supporters of assisted suicide and euthanasia have found the ultimate marketing technique to promote the normalization of assisted suicide and euthanasia: the presentation of a case history designed to show how necessary assisted suicide or euthanasia was in that particular instance. Such cases may rely either on nightmarish images of unnecessarily prolonged dying or on predictions of severe disability. The instance in which it is felt that most would agree it was desirable to end life is represented as typical. Those who participate in the death (the relatives, the euthanasia advocates, the physician) are celebrated as enhancing the dignity of the patient, who is usually presented as a heroic, fully independent figure.

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How much truth is there in this advertising? Does this accurately describe what happens? Even in cases advocates believe best illustrate the desirability of legalizing assisted suicide or euthanasia, there is ample room to question whether the death administered in fact realizes the patient's wishes and meets his or her needs. Advocates' desire to dramatize these model cases, moreover, requires that they be presented in some detail—and this creates the opportunity to see the discrepancy between theory and practice with regard to assisted suicide and euthanasia.

Death on Request

The ultimate attempt to normalize euthanasia in the Netherlands and make it seem an ordinary part of everyday life was the showing in the fall of 1994 on Dutch television of *Death on Request*,² a film of a patient being put to death by euthanasia. Maarten Nederhust, who created the film, found an agreeable patient and doctor by contacting the Dutch Voluntary Euthanasia Society.

The patient, Cees van Wendel, had been diagnosed as having amyotrophic lateral sclerosis in June 1993; he expressed his wish for euthanasia a month later. Severe muscular weakness confined him to a wheel chair; his speech was barely audible.

Almost 700,000 people saw the first showing of the film in the Netherlands. Subsequently, the right to show the film has been acquired by countries throughout the world. *Prime Time Live* excerpted and showed a representative segment to American viewers with a voiceover in English. Sam Donaldson introduced the program saying that it took no sides on the issue but added, "It is a story of courage and love."³ Only for the most gullible viewer.

In point of fact, the doctor, Wilfred van Oijen, is the film's most significant person. He is the manager who can make "everything"—even death—happen. He is presented as someone who has accepted the burden of all phases of experience. The patient is nearly invisible.

The film opens with a chilly scene in winter—trees are bare of leaves, it is cold, wet, inhospitable—not a bad

time to die. In an undershirt in his bathroom, the doctor combs his hair getting ready for just another day. His encounters will include treating a child of about ten months, a pregnant woman and a baby, and bringing death to Cees. The purpose of the film is to include euthanasia both as part of his daily burden as a doctor and as the natural course of events.

In the two house calls van Oijen makes to Cees, of most interest is the tension between the film's professed message—that all want release from illness, the patient most of all—and the message conveyed by what is actually filmed. The relationship depicted is between van Oijen and Antoinette, the patient's wife, who has called the doctor and clearly wants her husband to die.

The wife appears repulsed by her husband's illness, never touching him during their conversation and never permitting Cees to answer any question the doctor asks directly. She "translates" for him, although Cees is at this point in his illness intelligible, able to communicate verbally, but slowly, and able to type out messages on his computer. The doctor asks him if he wants euthanasia, but his wife replies. When Cees begins to cry, the doctor moves sympathetically toward him to touch his arm, but his wife tells the doctor to move away and says it is better to let him cry alone. During his weeping she continues to talk to the doctor. The doctor at no time asks to speak to Cees alone; neither does he ask if anything would make it easier for him to communicate or if additional help in his care would make him want to live.

Virtually the entire film is set up to avoid confronting any of the patient's feelings or how the relationship with his wife affects his agreeing to die. Cees is never seen alone. Van Oijen is obliged to obtain a second opinion from a consultant. The consultant, who appears well known to the doctor, also makes no attempt to communicate with Cees alone, and he too permits the wife to answer all the questions put to Cees. When the consultant asks the pro forma question if Cees is sure he wants to go ahead, Antoinette answers for him. The consultant seems uncomfortable, asks a few more questions, and leaves. The

consultation takes practically no time at all. The pharmacist who supplies the lethal medication—one shot to put Cees to sleep and another to help him die—seems only another player in this carefully orchestrated event.

Antoinette visits the doctor to ask where "we stand." She wants the euthanasia over with. Cees has set several dates, but keeps moving them back. Now he has settled on his birthday, and they arrange for van Oijen to do it at eight o'clock after Cees celebrates by drinking a glass of port. Cees makes a joke that sleeping is a little death but this time his sleep will be a lot of death. Van Oijen tries to laugh warmly. Antoinette keeps her distance from the two and remarks that the day has gone slowly and it seemed eight o'clock would never come.

Antoinette helps Cees into bed in preparation for van Oijen to administer the first shot. Van Oijen smiles, gives the injection, and explains the medication will take a while to put Cees into a deep sleep. No one says goodbye. Only after the shot has put Cees to sleep does Antoinette murmur something to her husband. She then moves into the other room with the doctor to permit Cees to sink into a deeper sleep. After a few minutes, they return. When the doctor wants to place Cees in a more comfortable position, she withdraws again. After the second shot is administered, Antoinette and van Oijen sit next to the bed, both holding the arm that has received the injections. Antoinette asks if this was good, presumably wanting to know if it was "good" to kill Cees. Van Oijen reassures her. They leave Cees alone very quickly. On the way into the next room, Antoinette takes a note Cees wrote to her about their relationship and what it meant to him and reads it to the doctor. She seems to want to convey to him that they in fact once had a relationship.

From the beginning, the loneliness and isolation of the husband haunts the film. Only because he is treated from the start as an object does his death seem inevitable. One leaves the film feeling that death with dignity requires more than effective management; it requires being accorded personhood even though one's speech

is slurred or one needs to point to letters on a board or communicate through writing on one's computer. Throughout the film, Cees's wife denies him such personhood, as does the doctor, who never questions her control over all of the patient's communication and even the doctor's communication with Cees. The doctor and wife took away Cees's personhood before ALS had claimed it.

A Good Death for Louise

An article featured on the cover of the *New York Times Magazine* in the fall of 1993 also used a case description to try to prove the value of assisted suicide to an American audience.¹ The article described the assisted suicide of Louise, a Seattle woman whose death was arranged by her doctor and the Reverend Ralph Mero, head of Compassion in Dying, a group that champions legalizing assisted suicide. Members of the group counsel the terminally ill, offer advice on lethal doses, convince cautious doctors to become involved, and are present during the death. Mero and his followers do not provide the means for suicide (the patients obtain such help from their doctors) and claim not to encourage the patients to seek suicide.

Mero arranged for a *Times* reporter to interview Louise in the last weeks of her life, offering Louise's death as an illustration of the beneficial effects of the organization's work. Yet the account serves equally to illustrate how assisted suicide made both life and death miserable for Louise.

Louise, who was referred to Mero by her doctor, had been ill with an unnamed, degenerative neurological disease. The reporter tells us that "Louise had mentioned suicide periodically during her six years of illness, but the subject came into sudden focus in May during a somber visit to her doctor's office." As Louise recounted it, "I really wasn't having any different symptoms. I just knew something had changed. I looked the doctor right in the eye and said, 'I'm starting to die.' And she said, 'I've had the same impression for a couple of days.'" An MRI scan confirmed that the frontal lobes of Louise's brain had begun to deteriorate, a sign that led her doctor to warn Louise

that her life would most likely be measured in months, perhaps weeks. Louise said her doctor explained that "she didn't want to scare me . . . she just wanted to be honest. She told me that once the disease becomes active, it progresses very fast, that I would become mentally incapacitated and wouldn't be myself, couldn't care for myself anymore. She would have to look into hospice care, or the hospital, or some other facility where I would stay until I died."

We are told that Louise did not hesitate with her answer. "I can't do that . . . I don't want that." The reporter continues, "Her doctor, Louise thought, looked both sad and relieved. 'I know, I know,' the doctor said. 'But it has to come from you.'" Louise makes sure that they are both talking about suicide and says, "That's what I'd like to do, go for as long as I can and then end it."

What has happened between Louise and her doctor? The doctor's quick affirmation that Louise is starting to die, even before the MRI scan confirms her decline, is disturbing. She prefaces a grim description of Louise's prognosis with assurance that she does not want to scare her. The doctor's relief when Louise indicates that she is choosing suicide gives us some feeling about her attitudes toward patients in Louise's condition.

As the account continues, the doctor indicates that she would be willing to help, had recently helped another patient whom Louise knew, and said she would prescribe enough barbiturates to kill Louise. To avoid legal trouble, she would not be there when Louise committed suicide. They exchanged several hugs and Louise went home. The doctor called Compassion in Dying for advice. The reporter quotes the doctor as saying about contacting Mero, "I was ecstatic to find someone who's doing what he's doing . . . I loved the fact that there were guidelines."

On the phone, Mero advises the doctor on the medication to prescribe and then visits Louise, suggesting that he is prepared to help Louise die before knowing or even meeting her or in any way determining whether she meets any guidelines. When he does meet Louise, she asks him at once if he will help her with her sui-

cide and be there when she does it and she is almost tearfully grateful when he says yes. He repeats many times that it has to be her choice. Louise affirms that it is, saying that all she wants "these next few weeks is to live as peacefully as possible." Louise seems concerned with being close to others during her final time and with spending what is left of her life in an environment of loving leave-taking.

The doctor is concerned that Louise's judgment might soon become impaired: "The question is, at what point is her will going to be affected, and, if suicide is what she wants, does she have the right to do it when she still has the will?" The doctor, like Mero, says she does not want to influence the patient, but worries that Louise might not act in time. "If she loses her mind and doesn't do this, she's going into the hospital. But the last thing I want to do is pressure her to do this."

Yet the closeness before dying that Louise seemed to want is lost in the flurry of activity and planning for her death as each of those involved with her dying pursues his or her own requirements. At a subsequent meeting of Mero and Louise, with Louise's mother and her doctor also present, Mero gives Louise a checklist in which he reviews steps to be taken during the suicide, from the food to be eaten to how the doctor would call the medical examiner.

The doctor indicates she will be out of town for the next week, but that she has told her partner of Louise's plans. "You don't have to wait for me to get back," she tells Louise, hinting, the reporter tells us, that it might be a good idea not to wait. The doctor was more direct when alone with Louise's mother, telling her that she was afraid Louise might not be coherent enough to act if she waited past the coming weekend.

The doctor and Mero discuss how pointed they can be with Louise, wanting her to make an informed decision without frightening her into acting sooner than she was ready. They hoped "she would read between the lines." Mero assures the reporter that he always wants to err on the side of caution. Nonetheless, a few days after the meeting, Mero called the reporter in New York, ask-

ing her to come to Seattle as soon as possible. He knew she was planning to come the following week, but he warned her not to wait that long.

The reporter leaves immediately for Seattle and finds Louise in a debilitated condition. She is in pain, getting weaker, and speaks of wanting to

flicking wishes—to live and to die—and found support only for the latter. The anxiety of her doctor, Mero, her mother, and her friend that Louise might change her mind or lose her "will" may originate in their desire to honor Louise's wishes, or even in their own view of what kind of life is

warm leave-taking and the affection they have had for Louise, but whether they can get her to die according to the time requirements of Mero, the doctor (who probably cannot stay away indefinitely), the reporter (who has her own deadlines), and the disease, which turns out to be on a more flexible schedule than previously thought, Louise is explicit that the doctor, mother, friend, and reporter have become instruments of pressure in moving her along. Mero appears to act more subtly and indirectly through his effect on the others involved with Louise.

Without a death there is, of course, no story, and Mero and the reporter have a stake in the story, although Mero has criticized Jack Kevorkian to the reporter for wanting publicity. The doctor develops a time frame for Louise; her own past troubling experience with a patient who was a friend seems to color the doctor's need to have things over with quickly and in her absence if possible. Louise is clearly frustrated by not having someone to talk to who has no stake in persuading her.

Individually and collectively those involved engender a terror in Louise with which she must struggle alone, while they reassure each other that they are gratifying her last wishes. The end of her life does not seem like death with dignity; nor is there much compassion conveyed in the way Louise was helped to die. Compassion is not an easy emotion to express in the context of an imminent loss. It requires that we look beyond our own pain to convey the power and meaning of all that has gone before in our life with another. Although the mother, friend, and physician may have acted out of good intentions in assisting the suicide, none appears to have honored Louise's need for a "peaceful" parting. None seems to have been able to accept the difficult emotions involved in loving someone who is dying and knowing there is little one can do but convey love and respect for the life that has been lived. The effort to deal with the discomfort of Louise's situation seems to drive the others to "do something" to eliminate the situation.

Watching someone die can be intolerably painful for those who care

If death with dignity is to be a fact and not a selling slogan, surely what is required is a loving parting that acknowledges the value of the life lived and affirms its continuing meaning.

end her life while she can still be in control. She says she is almost ready, but not quite. She needs about a week, mainly to relax and be with her mother.

The reporter blurted out, "Your doctor feels that if you don't act by this weekend you may not be able to." Her words are met with a "wrenching silence" and Louise, looking sharply at her mother, indicates that she hadn't been told that. Her mother says gently that is what the doctor had told her. Louise looks terrified and her mother tells her it's OK to be afraid. "I'm not afraid. I just feel as if everyone is ganging up on me, pressuring me," Louise said. "I just want some time."

Louise's mother was growing less certain that Louise would actually take her own life. When she tried to ask her directly, Louise replied, "I feel like it's all we ever talk about." A friend who had agreed to be with Louise during the suicide is also uncomfortable with Louise's ambivalence but is inclined to attribute her irritability and uncertainty to her mental decline. When Louise indicates that she would wait for Mero to return from a trip and ask his opinion on her holding on for a few days, the friend indicates that this was a bad idea since the change in her mood might be missed by someone like Mero who did not know her well.

Like many people in extreme situations, Louise has expressed two con-

worth living, but eventually overrides the emotions Louise is clearly feeling and comes to affect what happens more than Louise's will. Although those around her act in the name of supporting Louise's autonomy, Louise begins to lose her own death.

Despite predictions, Louise makes it through the weekend. Over the next days she speaks with Mero by phone, but he tells the reporter he kept the conversations short because he was uncomfortable with her growing dependence on his opinion. Nevertheless, after a few such conversations, the contents of which are not revealed, Louise indicated she was ready; that evening Mero came and the assisted suicide was performed. A detailed description of the death scene provides the beginning, the end, and the drama of the published story. Louise did not die immediately but lingered for seven hours. Had she not died from the pills, Mero subsequently implied to the reporter, he would have used a plastic bag to suffocate her, although this violates the Compassion in Dying guidelines.

Everyone—Mero, the friend, the mother, the doctor, and the reporter—all became part of a network pressuring Louise to stick to her decision and to do so in a timely manner. The death was virtually clocked by their anxiety that she might want to live. Mero and the doctor influence the feelings of the mother and the friend so that the issue is not their

for the patient. Their wish to have it over with quickly is understandable. Their feeling can become a form of pressure on the patient and must be separated from what the patient actually wants. The patient who wants to live until the end but senses his family cannot tolerate watching him die is familiar to those who care for the terminally ill. Once those close to the patient decide to assist in the suicide, their desire to have it over with can make the pressure put on the patient many times greater. The mood of those assisting is reflected in Macbeth's famous line, "If it were done when 'tis done, then 'twere well it were done quickly."

Certainly assisted suicide—the fact that she took the lethal medication herself—offered no protection to Louise. Short of actually murdering her, it is hard to see how her doctor, Mero, her mother, her friend, and the reporter could have done more to rush her toward death. Case vignettes limited to one or two paragraphs describing the patient's medical symptoms, and leaving out the social context in which euthanasia is being considered, obscure such complexity—and often subtle—pressures on patients' "autonomous" decisions to seek death.

Empowerment for Whom?

Our culture supports the feeling that we should not tolerate situations we cannot control. "Death," Arnold Toynbee has said, "is un-American." The physician who feels a sense of failure and helplessness in the face of incurable disease, or the relative who cannot bear the emotions of loss and separation, finds in assisted suicide and euthanasia an illusion of mastery over the disease and the accompanying feelings of helplessness. Determining when death will occur becomes a way of dealing with frustration.

In the selling of assisted suicide and euthanasia words like "empowerment" and "dignity" are associated only with the choice for dying. But who is being empowered? The more one knows about individual cases, the more apparent it becomes that needs other than those of the patient often prevail. "Empowerment" flows toward the relatives, the doctor who offers a

speedy way out if he cannot offer a cure, or the activists who have found in death a cause that gives meaning to their lives. The patient, who may have said she wants to die in the hope of receiving emotional reassurance that all around her want her to live, may find that like Louise she has set in motion a process whose momentum she cannot control. If death with dignity is to be a fact and not a selling slogan, surely what is required is a loving parting that acknowledges the value of the life lived and affirms its continuing meaning.

Euthanasia advocates try to use the individual case to demonstrate that there are some cases of rational or justifiable assisted suicide or euthanasia. If they can demonstrate that there are *some* such cases, they believe that would justify legalizing euthanasia.

Their argument recalls Abraham's approach in persuading God not to go ahead with his intention to destroy everyone in Sodom. Abraham asks if it should be right for God to destroy Sodom if there were fifty who were righteous within the city. When God agrees to spare Sodom if there were fifty who were righteous, Abraham asks what about forty-five, gradually reduces the number to ten, and gets God to spare the city for the time being for the sake of the ten.

Abraham, however, is arguing in favor of saving life; we want him to succeed and are relieved that he does. Euthanasia advocates are arguing that if there are ten cases where euthanasia might be appropriate, we should legalize a practice that is likely to kill thousands inappropriately.

The appeal of assisted suicide and euthanasia is a symptom of our failure to develop a better response to death and the fear of intolerable pain or artificial prolongation of life. The United States needs a national commission to explore and develop a consensus on the care and treatment of the seriously or terminally ill—a scientific commission similar to the President's Commission that in 1983 gave us guidelines about forgoing life-sustaining treatment with dying patients. Work of a wider scope needs to be done now. There is a great deal of evidence that doctors are not sufficiently trained in relieving pain and other symptoms in the terminally ill.

Hospice care is in its infancy. We have not yet educated the public as to the choices they have in refusing or terminating treatment nor has the medical profession learned how best to avoid setting in motion the technology that only prolongs a painful process of dying. And we have not devoted enough time in our medical schools or hospitals to educating future physicians about coming to terms with the painful truth that there will be patients they will not be able to save but whose needs they must address.

How we deal with illness, age, and decline says a great deal about who and what we are, both as individuals and as a society. We should not buy into the view of those who are engulfed by fear of death or by suicidal despair that death is the preferred solution to the problems of illness, age, and depression. We would be encouraging the worst tendencies of depressed patients, most of whom can be helped to overcome their condition. By rushing to "normalize" euthanasia as a medical option along with accepting or refusing treatment, we are inevitably laying the groundwork for a culture that will not only turn euthanasia into a "cure" for depression but may prove to exert a coercion to die on patients when they are most vulnerable. Death ought to be hard to sell.

References

1. Yale Kamisar, "Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia," in *Examining Euthanasia*, ed. John Keown (Cambridge: Cambridge University Press, in press); Yale Kamisar, "Are Laws against Assisted Suicide Unconstitutional?" *Hastings Center Report* 23, no. 3 (1993): 33-41; Herbert Hendin, "Seduced by Death: Doctors, Patients and the Dutch Cure," *Issues in Law and Medicine* 10, no. 2 (1994): 123-68; Carlos Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* (New York: Free Press, 1991).
2. "Death on Request," Ikon Television Network, 1994.
3. "Death on Request," *Prime Time Live*, 8 December 1994.
4. Lisa Belken, "There's No Simple Suicide," *New York Times Magazine*, 14 November 1993.

V. Special Topics

15

Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience

Herbert Hendin, MD

What impact would legalization of assisted suicide and euthanasia have on our ability to treat suicidal patients and to prevent suicide? Information from a study of the Dutch experience illustrates how legal sanction promotes a culture that transforms suicide into assisted suicide and euthanasia and encourages patients and doctors to see choosing death as a preferred way of dealing with serious or terminal illness. The extension of the right to euthanasia to those who are not physically ill further complicates the problem. So too does the tendency of doctors in such a culture to begin to feel that they can make decisions about ending the life of competent terminally ill patients without consulting the patient. "Normalizing" suicide as a medical option lays the groundwork for a society that turns euthanasia into a "cure" for suicidal depression.

Many of us have known situations in which a doctor would have acted humanely by helping a terminally ill person die in the final weeks of an illness. Many of us have also seen patients whose first reaction to the knowledge of serious illness and possible death is anxiety, depression and a wish to die (Hendin & Klerman, 1993). Whenever, as in the Netherlands, or in a law passed by Oregon voters in 1994 (now under a preliminary injunction pending a trial as to its constitutionality) there is legal sanction for assisted suicide for patients who are not in the last weeks of their life, and indeed who need not be experiencing severe discomfort or physical pain, the terminally ill become hopelessly confused with those who are not.

My observations in the Netherlands, where doctors following accepted guidelines, can with impunity and public acceptance practice assisted suicide and euthanasia, persuade me that legalization of these practices is not the answer to the problems of those confronted with serious illness (Hendin, 1994a). Legalization also

complicates and confuses the treatment of patients who are suicidal.

De facto legalization of euthanasia and assisted suicide exists in the Netherlands (Gomez, 1991). Although the criminal law provides punishment for euthanasia and a lesser punishment for assisted suicide (Gevers, 1992), the same code stipulates that there can be exceptions to the law in special circumstances. In a series of cases over 20 years, the Dutch courts have ruled that assisted suicide and euthanasia are such special circumstances. They are permitted by a physician who found it necessary to put the welfare of his patient above the law which formally prohibits assisted suicide and euthanasia (Gomez, 1991).

The Dutch courts and the Royal Dutch Medical Association (KNMG) have established the same guidelines for physicians to follow whether in practicing assisted suicide or euthanasia: 1) voluntariness—the patient's request must be freely made, persistent, and conscious; 2) unbearable suffering that cannot be relieved by other

means; and 3) consultation—the attending physician should consult with a colleague (KNMG, 1984). Doctors are expected to report cases of euthanasia as deaths due to “unnatural causes” with the understanding that prosecutors will not prosecute if the guidelines were followed.

Few cases have been brought to trial. The recommended guidelines are not fixed conditions so that even when they were not followed, judges have consistently exonerated or pardoned physicians (Gomez, 1991). A statute passed last year codifying the guidelines provides added protection for doctors—but not for patients (Hendin, 1994b).

Over the past 20 years practice in the Netherlands has moved from assisted suicide to euthanasia, from euthanasia for the terminally ill to euthanasia for patients who are chronically ill, from physical suffering to mental suffering, from voluntary euthanasia to involuntary euthanasia (called “termination of the patient without explicit request”). The Dutch government’s own commissioned research documented that in more than one thousand cases a year, doctors actively caused death without the patient’s request (van der Maas, van Delders, and Pijnenborg, 1992).

The rationale for such extensions has been that to deny the right to die with assistance to the chronically ill who will have longer to suffer than the terminally ill or to those who experience psychological pain not associated with physical disease is a form of discrimination. Ending patients’ lives without their request has been justified as necessitated by the need to make decisions for patients not competent to choose for themselves.

SUICIDE IN THE NETHERLANDS

The Dutch experience illustrates how social sanctions promote a culture that transforms suicide into assisted suicide and euthanasia and encourages patients and doctors to see assisted suicide and euthanasia—intended as an unfortunate ne-

cessity in exceptional cases—as almost a routine way of dealing with serious or terminal illness and more recently even with grief. The Dutch like to point out that they have a relatively low suicide rate and that since the acceptance of euthanasia that rate has not increased, but dropped. But many of the cases of euthanasia are likely to be people who would have ended their own lives if euthanasia were not available to them. This was certainly one of the justifications given by Dutch doctors for providing such help. If any significant percentage of the euthanasia cases were to be included among the suicides, the Dutch figure would rise considerably.

In fact the figures suggest that the drop in the Dutch suicide rate from a peak of 16.6 in 1983 and 1984 to 12.8 in 1992 (see Table 1) may well be due to the availability of euthanasia. More significant than the drop is the fact that it has taken place in the older age groups. In the 50-59 age group the rate dropped from a peak of 21.5 in 1984 to 14 in 1992. Among those 60-69 the rate dropped from a peak of 23.2 in 1982 to 14.5 in 1992. Among those 70 and over the rate dropped from a peak of 31.3 in 1983 to 19.9 in 1992. These are remarkable drops of about 33% in these 3 groups. Of the 1886 suicides in 1993, 940 of them were in the three older age groups. Of the 1587 suicides in 1992, 672 were in the three older age groups. The drop of 268 suicides in the three older age groups was primarily responsible for the drop in the Dutch suicide rate. Comparing the five years of 1980-1984 with the 1988-1992 years provides statistically significant evidence of a drop in the older age groups that is not due to chance. These are the age groups containing the highest numbers of euthanasia cases (86% of the men and 78% of the women) and the greatest number of suicides (see Table 2).

The period of the last decade is the period of growing Dutch acceptance of euthanasia. It seems plausible that the remarkable drop in the older age groups is due to the fact that older suicidal patients are now asking to receive euthanasia. Among an older population physical ill-

Table 1
Relative Number per 100,000 of Corresponding Community 15 Years of Age or Older

Year	Sex ^a		Total number	Age group ^b							
	Male	Female		≤ 15	16-19	20-29	30-39	40-49	50-59	60-69	≥ 70
1970	15.3	9.2	12.2		2.9	6.6	7.6	13.2	18.2	21.0	26.2
1971	15.3	10.1	12.7		4.2	6.7	7.6	12.4	19.9	20.4	28.0
1972	15.3	9.7	12.5		3.8	7.1	9.4	13.0	17.0	21.9	24.0
1973	15.1	10.7	12.9		4.1	6.9	10.0	13.6	20.0	20.0	20.8
1974	16.5	10.7	13.5		4.8	8.5	10.4	15.3	17.7	21.6	24.0
1975	16.1	10.3	13.2		4.1	8.9	11.4	14.7	18.0	18.3	23.1
1976	17.3	10.1	13.6		3.7	9.0	12.6	13.8	18.7	19.3	25.6
1977	16.9	9.7	13.3		3.8	9.8	11.2	15.1	17.9	18.3	22.2
1978	16.0	11.4	13.7		3.6	11.1	11.4	15.0	16.1	23.5	20.8
1979	16.7	12.7	14.7		4.2	9.9	11.2	18.3	21.2	21.6	24.3
1980	18.4	10.3	14.3		2.3	12.0	12.8	14.7	17.8	21.5	22.3
1981	18.8	11.1	15.0		2.8	11.3	13.5	16.0	18.6	22.4	22.3
1982	19.3	12.3	15.8		4.6	11.4	13.4	17.5	18.8	23.1	27.3
1983	20.7	12.8	16.6		2.5	12.2	14.5	17.4	21.0	23.2	31.3
1984	20.6	12.7	16.6		3.0	12.0	15.4	18.1	21.5	22.3	27.9
1985	19.8	10.7	15.2		3.7	12.6	14.7	15.1	19.1	20.6	22.3
1986	18.7	11.1	14.8		2.8	11.5	14.3	16.6	17.8	19.7	23.1
1987	19.1	11.1	15.0		3.5	11.9	14.7	15.9	17.9	19.6	24.2
1988	17.9	9.9	13.7		2.6	10.7	13.6	14.0	17.4	17.0	23.2
1989	17.6	10.2	13.8		4.0	10.9	12.5	14.3	19.0	19.6	18.3
1990	17.1	9.7	13.3		4.5	9.6	14.1	13.9	15.0	16.2	21.3
1991	17.2	9.2	13.1		3.1	9.9	14.6	12.9	15.5	15.5	19.9
1992	17.2	8.7	12.8		3.5	9.5	13.7	13.7	14.0	14.5	19.9

Source. Central Bureau of Statistics, revised by Central Directory for the Development of Scientific Policy, July 1994.

^aUnknown sex included.

^bIn the period 1970-1979, the CBS registered by the age groups of 15-20 and 21-29 years. In the period 1980-1992 the age groups became 15-19 and 20-29 years. Because of this change, the real group of 15-19 years will be slightly less and the real group 20-29 will be slightly higher in the period 1970-1979.

^cUnknown.

ness of all types is common, and many who have trouble coping with physical illness became suicidal. In a culture accepting of euthanasia their distress may be accepted as a legitimate reason for euthanasia. It may be more than metaphorical to describe euthanasia as the Dutch cure for suicide.

Of course euthanasia advocates can maintain that making suicide unnecessary for those over 50 who are physically ill is one of the benefits of legalization, not a sign of its abuse. The acceptance of such a position depends on whether one believes that there are alternatives to assisted suicide or euthanasia in dealing with the pain, suffering, and depression of older people who become ill.

FEAR OF DEATH

Depression, anxiety and the wish to end one's life quickly are often first reactions to the knowledge of serious illness and possible death. In studies of assisted suicide and euthanasia, most of which have been done in the Netherlands, physicians reported that loss of dignity, pain, being dependent on others were the reasons patients have for requesting euthanasia (van der Maas, van Delders and Pijnenborg, 1992). The fear of death itself is not mentioned.

Many patients and physicians displace anxieties about death onto the circumstances of dying—pain, dependence, loss of dignity, the unpleasant side effects re-

Table 2
Number of Suicides in The Netherlands from 1970 to 1992

Year	Sex ^a		Total number	Age group ^b							
	Male	Female		≤ 15	16-19	20-29	30-39	40-49	50-59	60-69	≥ 70
Absolute Number											
1970	719	439	1158	10	39	123	121	199	232	220	213
1971	727	489	1216	— ^c	56	130	122	188	259	216	242
1972	740	480	1220	—	51	141	153	198	225	235	212
1973	738	535	1273	14	51	163	165	205	268	217	189
1974	815	545	1360	9	66	175	177	232	239	238	224
1975	810	533	1343	—	57	187	199	223	246	203	219
1976	885	528	1413	—	53	190	228	211	259	215	251
1977	871	513	1384	—	55	206	210	232	249	205	221
1978	841	617	1458	—	52	230	229	233	228	264	215
1979	884	693	1577	—	61	206	229	284	301	242	254
1980	981	576	1557	4	32	281	269	231	257	241	242
1981	1023	627	1656	10	35	269	293	254	268	257	245
1982	1063	703	1772	9	58	272	297	281	273	270	306
1983	1150	736	1886	10	31	294	328	283	306	275	359
1984	1160	742	1902	9	37	293	353	302	313	268	327
1985	1127	633	1760	8	46	310	343	257	278	251	267
1986	1076	664	1740	6	35	288	338	288	261	243	281
1987	1114	670	1784	3	45	296	344	294	263	245	294
1988	1054	604	1658	8	31	270	317	271	257	214	290
1989	1045	629	1674	4	47	278	292	288	283	251	231
1990	1021	599	1620	7	50	246	333	289	226	197	272
1991	1033	578	1611	3	32	255	349	274	236	202	260
1992	1041	546	1587	3	35	245	333	299	216	190	266

Source. Central Bureau of Statistics, revised by Central Directory for the Development of Scientific Policy, July 1994.

^aUnknown sex included.

^bIn the period 1970-1979, the CBS registered by the age groups of 15-20 and 21-29 years. In the period 1980-1992 the age groups became 15-19 and 20-29 years. Because of this change, the real group of 15-19 years will be slightly less and the real group 20-29 will be slightly higher in the period 1970-1979.

^cUnknown.

sulting from medical treatments. Focusing on or becoming enraged at the process distracts from the fear of death itself.

Confronting such fear may focus a patient on what he can achieve in whatever life can still offer. A few years ago, a young professional in his early 30's who had acute myelocytic leukemia, was referred to me for consultation. With medical treatment, Tim was given a 25% chance of survival; without it, he was told, he would die in a few months.

His immediate reaction was a desperate preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease

and the side effects of treatment. His anxieties about the painful circumstances that would surround his death were not irrational, but all his fears about dying amplified them.

Once Tim and I could talk about the possibility or likelihood of his dying—what separation from his family and the destruction of his body meant to him—his desperation subsided. He accepted medical treatment, complained relatively little about the unpleasant side effects, and used the remaining months of his life to become closer to his wife and parents. Two days before he died, he talked of what he would have missed without the opportunity for a loving parting (Hendin, 1994a).

In the Netherlands the fear of death can lead to the premature ending of life. Even in a film intended to promote euthanasia, "Appointment with Death" that I was shown at the Dutch Voluntary Euthanasia Society (K.A. Productions, 1993), I saw such an example. A 41-year-old artist was diagnosed as HIV positive. He had no physical symptoms, but had seen others suffer with them and wanted his physician's assistance in dying. The doctor compassionately explained to him that he might live for some years symptom-free. Over time the patient repeated his request for euthanasia and eventually his doctor acceded to it. The patient was clearly depressed and overwhelmed by the news of his situation. The doctor kept establishing that the man was persistent in his request, but did not address the terror that underlay it. I was convinced that with a psychologically sensitive physician looking for more than repeated requests to die, more likely in a culture not so medically accepting of euthanasia, this man would not have needed to die when he did (Hendin, 1994a).

If the ravages of illness and the painful side effects of treatment were not accompanied by the fear of imminent death they would be more bearable and many who choose death might well not do so. Conversely, if life were so structured that we all knew that we would die on the day of our 85th birthday, but live in good health up to that time, it is likely that many people would kill themselves in the months or years prior to that time so as to avoid anxiety over the inevitability of their fate and their lack of control over it (Hendin, 1994).

Patients are not alone in their inability to tolerate situations they cannot control. Lewis Thomas (1984) has written insightfully from the physician's viewpoint of the sense of failure and helplessness that doctors may experience in the face of death. Such feelings might explain why doctors have such difficulty in discussing terminal illness with patients—a majority of doctors avoid such discussions while most patients would prefer frank talk. They might also explain both the doctor's ten-

dency for excessive measures to maintain life in the dying as well as the need to make death a physician's decision. By deciding when patients die, by making death a medical decision, the physician has the illusion of mastery over the disease and the accompanying feelings of helplessness. The physician, not the illness, is responsible for the death. Assisting suicide and euthanasia become ways of dealing with the frustration of being unable to cure the disease (Hendin, 1994a).

ASSISTED SUICIDE FOR DUTCH PSYCHIATRIC PATIENTS

How Dutch policies translate into practice with a psychiatric patient are evident in a case that has received a good deal of international attention. I had a chance to spend a number of hours interviewing the psychiatrist involved (Hendin, 1994a). In the spring of 1993 a Dutch court in Assen ruled that Boudewijn Chabot was justified in assisting in the suicide of his patient a physically healthy but grief-stricken 50-year-old social worker who was mourning the death of her son two months earlier.

Chabot had accepted his patient, to whom he gave the fictional name of Netty Boomsma (Chabot, 1993) into treatment in the summer of 1991 with the understanding, common in the Netherlands, that if she did not change her mind about not wanting to live, he would assist in her suicide. Netty appears to have used the agreement to mark time until Chabot felt obliged to fulfill his promise. He assisted in her suicide a little over two months after she came to see him, about four months after her younger son died of cancer at 20. Her first son had killed himself some years earlier following a rejection by his girlfriend.

Chabot told me that Netty's marriage was a disaster from the beginning. She was 23 and her husband was 28. She was not really in love but married her husband to get away from an unpleasant relationship with a domineering mother and a

father who went along with whatever her mother wanted. Her husband believed a woman should stay at home which she did for a while, but felt in a cage until she decided to work and earn her own money. Netty told Chabot she started to live the day her first child was born. The child made it possible for her to be something apart from her disapproving mother. Six years later she had her second son. When her children were small she went to social work school at night, while she held a job which she enjoyed during the day. Netty continued to work until January 1990 which was the start of her son's chemotherapy for his cancer.

Netty's husband blamed her for their first son's death saying she was responsible for his education so was responsible for his suicide. He would beat up Netty when he was drunk. She would leave him, but then she would have to go back because of her second son. She planned at one point to kill herself and her second son by driving into a canal, but felt she could not take his life.

Three years before Netty's death, and a few weeks after her father died, Netty left her husband and her son went with her. By then her son had become a comfort for her. He understood her grief and tried to console her. Over the years he became more important to her. Since his death Netty felt that although not a religious believer she was "pulled to her boys."

Chabot had been told by Netty's sister and brother-in-law that although Netty was somewhat better than when her first son died (she had been hospitalized at that time) her energy and interest in many activities, particularly painting, had subsided and never returned after her first son's death. Netty blamed herself for not having divorced her husband earlier, believing that had she done so, things might have been different and her son might not have killed himself.

Chabot described the case in a written account he sent a number of colleagues. Although two did not think he should go forward and felt bereavement therapy was indicated, an expert in bereavement

therapy thought it was futile and the majority agreed that Chabot should proceed. None felt it was necessary to actually see the patient.

Chabot described the scene the night he assisted in Netty's death. He went with a colleague to Netty's home and Netty had a friend with her. She said she wanted to go ahead. She asked to do it in the room of her younger son and on his bed. They all went upstairs and he gave her a liquid as well as some capsules that a pharmacist had prepared for him. She opened the capsules as she had been advised and put them in some yogurt. Jokingly she asked him if he could not have given her some capsules before to practice. She sat down on the bed and asked them to turn on the record player which played a Bach flute sonata that had been played at her son's funeral. She took the glass and drank the liquid saying that it was not too bad. While the music was playing Netty kissed a photograph of her two sons that was next to the bed. She asked her friend to sit next to her. Her friend was stroking her hair. Netty said she had made a great effort to fix her hair and her friend was messing it up. The friend replied she would make it beautiful later. To Chabot, Netty said, "why do young kids want suicide," thinking of her son. He recalled saying to her after five minutes, "think of your boys." In seven minutes she lost consciousness while being held by her friend. Then she slept. Her heart stopped in one half hour.

Chabot insisted that Netty was not depressed, was not a patient, but simply a grieving woman who wanted to die. Although Netty had not exhibited the sad affect associated with depression, patients obsessively bent on suicide often do not. In the loss of pleasure that Netty experienced in activities she previously enjoyed, Netty surely met that aspect of the criteria established for the diagnosis of depression. In the sense, however, that any therapy would have required challenging the premises under which she came, and would probably have also included some trial on medication, no therapy could be

said to have been undertaken with Netty so one can understand why Chabot does not regard her as a patient.

Chabot stated that if he did not agree to her terms she would have never come back. She had also threatened to take matters into her own hands. I asked why if she did not follow his prescription for treatment, he would feel obliged to follow hers. Certainly at the end he seemed to be succumbing to blackmail.

Chabot and a number of other Dutch therapists believe there is an obligation to assist in the suicide of a suicidal patient if treatment has not succeeded. They point to cases that they had been able to involve in psychotherapy because of the promise that if treatment did not work they would assist in their patients' suicides. Most therapists, however, find that such patients can be involved in therapy without such a promise by making it clear that they accept suicidal feelings as part of the therapy, are not uncomfortable or frightened by them, and will not go to any lengths to stop the patient's suicide, conveying that ultimately the patient is responsible for being alive.

Many suicidal patients come into therapy with sometimes conscious, but often unconscious fantasies that cast the therapist in the role of their executioner. Netty seemed to be such a patient; both she and Chabot experienced a closeness in her death. A commitment on the therapist's part to become executioner if treatment fails plays into and reinforces these fantasies. It may also play into the therapist's illusion that if he cannot cure the patient no one else can either.

Some therapists also seem to have entered into the patient's fantasy of death as a reunion. Chabot's comment to Netty right before her death that she should think about her boys suggests that he too saw her death metaphorically as a return to her lost children. By metaphorizing death as something other than death, it is made to appear an attractive, fairytale-like option. But such metaphors, like fairytales, contain beneath the surface some of the most tormented and savage

emotions there are. Not treating Netty as a patient, but as a devoted mother whose desire to join her boys in death was not a sign of her disturbance but a legitimate and realizable goal makes it impossible to explore her guilt toward her children and her need for punishment.

From what Chabot was able to elicit in sessions with Netty, bereavement counseling was likely to fail with her, but psychotherapy less narrowly focused might succeed. Netty's personality problems far anteceded her bereavement. She said she became a person only when her first son was born and stayed alive only for the sake of her second son.

Netty needed someone who could tell her in a firm but kind way that she never really lived for herself and that it was not too late to try. She could always kill herself but she ought to give life a chance first. Netty's guilt over her first son's suicide had sources that were deeper than her failure to have gotten a divorce. Caring for her second son seems to have had something of the quality of an atonement. One suspects that if therapy provided her with the opportunity to understand her relationship to her sons before deciding to join them in death, it might have engaged her.

No one should underestimate the grief of a mother who has lost a beloved child, but neither should one ignore the many ways life offers to deal with the feelings of loss, guilt and pain a child's death is likely to arouse. The Dutch like to present patients with concrete alternatives. For Netty, my suggestion would be to utilize her skills as a social worker and involve her in a facility or project devoted to youth suicide prevention. Her last words to Chabot, "why do young kids want suicide," suggest that work that permitted her to deal with that question might have meaningfully engaged her in a way that would have been more positive for her as well as for those she might have helped. In any case with or without help time alone was likely to have altered her mood.

The Dutch Supreme Court which ruled on the Assen Case in June 1994 agreed with the lower courts in affirming that

mental suffering can be grounds for euthanasia, but found Chabot guilty of not having had a psychiatric consultant actually see the patient. Although the court expressed the belief that a consultant's direct contact with a patient was particularly necessary in the absence of physical illness, it imposed no punishment since it felt that in all other regards Chabot had behaved responsibly. The case was seen as a triumph by euthanasia advocates since it legally established mental suffering as a basis for euthanasia. Since the consultation can easily be obtained from a sympathetic colleague, it offers the patient little protection.

In another well-publicized psychiatric case, described in a Dutch psychiatric journal (Schudel, Nolen, van Dijk and Sutorius, 1993), a patient who was chronically depressed with major depressive episodes in which he was psychotic was, between psychotic episodes, assisted in his suicide by his psychiatrist. The justification for acceding to the patient's request had been that he had not responded to treatment, that his suffering was unbearable and that in between the major depressive psychotic episodes he was competent.

The acceptance of euthanasia for psychiatric patients who are suicidal seems the inevitable consequence of allowing such criteria as "competence" and "intolerable suffering" to determine the outcome rather than sound clinical judgment. The psychiatrist in some of the psychiatric cases is in the position of working to prevent suicide until the patient asks for his assistance in committing suicide and then the rules of the game change and he negotiates with the patient as to whose approach is best.

Seriously suicidal patients want suicide. In a society that makes euthanasia accessible for them they will be harder to treat, not easier. Many of them fantasize closeness in death with a person who kills them. When psychiatrists and general practitioners have complementary fantasies, euthanasia fulfills their needs as much as the patient's.

Dutch practice ignores what we know of complex dynamics of the relation between the treatment of the suicidal and the desire of some who are seriously ill to end their lives. Suicidal patients are prone to make conditions on life that life cannot fulfill: "I won't live if I can't be in control", "... without my husband," "... if I lose my looks, power, prestige or health," or "if I am going to die soon" (Hendin, 1982). Depression, often precipitated by discovering a serious illness, exaggerates the tendency toward seeing problems in black-or-white terms (Hendin and Klerman, 1993). Although clinical and research experience confirm that the overwhelming majority of suicidal patients including the terminally ill suffer from a depression that can be treated (Brown, Henteleff, Barakat and Rowe, 1975), when a patient finds a doctor who shares the view that life is only worth living if certain conditions are met, the patient's rigidity is reinforced (Hendin, 1994a).

THE REMMELINK REPORT

Despite accepting euthanasia, the Dutch did not find hard facts about it easy to come by. Estimates of the number of euthanasia cases ranged from five thousand to twenty thousand of the 130,000 deaths in the Netherlands each year. Charges that involuntary euthanasia was widespread were made.

To ascertain actual Dutch medical practice regarding euthanasia, a government commission, headed by Professor Jan Rummelink, arranged a remarkable study of the problem by investigators at Erasmus University in which physicians were granted anonymity and immunity from prosecution. The Rummelink Report found that 49,000 deaths in the Netherlands each year involve a medical decision at the end of life (MDEL). 95% of these MDEL cases involve, in equal numbers, either withholding/discontinuing life support, or the alleviation of pain and symptoms through medication that might hasten death. Frank euthanasia was the cause of death in 2,300 i.e. in 2% of all

Dutch deaths. Assisted suicide was relatively uncommon, occurring some 400 times per year. Over 50% of Dutch physicians admitted to practicing euthanasia, with cancer patients being the majority of their cases. Only 60% of doctors kept a written record of their cases, and only 29% of doctors filled out the death certificates honestly in euthanasia cases (van der Maas, van Delders, Pijnenborg, 1991).

That it is often the doctor and not the patient who determines the choice for death was underlined by the Rummelink Report's documentation of cases in which there has been "termination of the patient without explicit request" (van der Maas, van Delders and Pijnenborg, 1992). The term "involuntary euthanasia," disturbing to the Dutch, is avoided by their definition of euthanasia as the ending of the life of one person by another at the first person's request. If life is terminated without request they consider it not to be euthanasia (Borst-Eilers, 1992). "Involuntary euthanasia" seems, however, to have a far less Orwellian connotation than "termination of the patient without explicit request."

In the 1,000 cases referred to earlier where physicians admitted they had actively caused or hastened death without any request from the patient, the impossibility of treating pain effectively was given as the reason for killing the patient in only 30%. The remaining 70% were killed with a variety of different justifications ranging from "low quality of life" to "a therapy was withdrawn but the patient did not die." 27% of physicians indicated that they had terminated the lives of patients without a request from the patient to do so; another 32% could conceive of doing so (van der Maas, van Delders and Pijnenborg, 1992).

Other forms of hastening death without the patient's consent are, according to the Report, common practice in the Netherlands. In over 4,000 cases the doctor's explicit intention in administering pain medication or withdrawing or withholding treatment was to shorten life; in almost 11,000 cases this was a secondary goal." In over half of the 49,000 MDEL cases,

apart from the euthanasia cases, decisions that might or were intended to end the life of the patient without consulting the patient. In about 80% of these cases physicians gave the patient's impaired ability to communicate as their justification. This left about 5,000 cases in which physicians made decisions that might or were intended to end the lives of competent patients without consulting them.

In 13% of these cases, physicians who did not communicate with competent patients concerning MDELs that might or were intended to end their lives gave as a reason for not doing so that they previously had some discussion of the subject with the patient. Yet it seemed incomprehensible that the physician would terminate the life of a competent patient on the basis of some prior discussion without checking if the patient still felt the same way. One could only conjecture that the physician, actually knowing that the patient would not agree or had changed his mind, did not want to hear the answer because he felt it appropriate to end the patient's life and to do so after a negative reply would amount to murder. Another possibility was that the physician was justifying the death by stretching the patient's prior statement which may, according to the study, have been no more than an urgent request for pain medication.

Physicians were not challenged with regard to explanations in the study. Indeed their not being challenged was a necessary condition to secure the cooperation of the KNMG and the participating doctors. I had the impression that the study's interviewers, who were primarily physicians, were questioning their colleagues in a somewhat collegial manner, a limitation of this otherwise valuable report (Hendin, 1994a).

Some euthanasia advocates defend the need for doctors to make decisions to end the lives of competent patients without discussion with them. One euthanasia advocate gave me as an example a case where a doctor had terminated the life of a nun a few days before she would have died because she was in excruciating pain, but

her religious convictions did not permit her to ask for death. He did not argue, however, when asked why she should not have been permitted to die in the way she wanted.

Other advocates admit that a system in which doctors become used to playing a predominant role in making decisions about ending life encourages some to feel entitled to make decisions without consulting patients. Many of the professionals who are advocates of euthanasia conceded that abuses were common. In their published articles, however, they do not admit this since they see the issue of euthanasia as caught in a political struggle in which conceding abuses would give ammunition to those in government who are critical of the system.

Many Dutch psychologists and psychiatrists were privately critical of Chabot's assistance in the suicide of Netty Boomsma. That assisted suicide and euthanasia are advocated and supported by both the medical and legal establishments makes it difficult for them to say so publicly or in writing; only one has done so (Koerselman 1994).

DISCUSSION

Virtually all Dutch advocates of euthanasia familiar with the United States see our legalizing euthanasia as unwise for a variety of reasons. From their perspective, the United States is not characterized by either a legal or medical system that fosters social harmony, but instead pits one profession against the other. They believe the tendency of American patients in general to litigation would make euthanasia a nightmare for physicians. They cite social and economic disparities in health care as another source of contention and recognize that without comprehensive care for the sickly poor and the elderly, euthanasia will tend to become their only option. The Dutch believe their hospitals are not subject to the economic pressure to get rid of the terminally ill that would be present in this country. The relative absence of the family doctor, the core of medical practice

in the Netherlands, eliminates what the Dutch perceive as a major source of patient protection. Further contaminating the process in the United States would be the difficulty of preventing the profit motive from making euthanasia and assisted suicide a lucrative business.

Yet even a more equitable health care system and twenty years of experience have not protected the Dutch from the abuses of their system. In our country proposals for legislation have been hastily introduced to a public with little opportunity to develop an informed consensus.

The law recently passed in Oregon would permit doctors to prescribe lethal drugs to patients judged to be in the last six months of life. It is not just that it is impossible to predict with certainty that a patient has only six months to live, making mistaken or falsified predictions inevitable. Any law that permits assisted suicide when patients are neither in pain nor immediately about to die will encourage people who fear death to take a quicker way out.

Under the Oregon law, Tim, the patient with acute myelocytic leukemia, would probably have asked a doctor's help in taking his own life. Because he was mentally competent and did not meet the clinical criteria for a diagnosis of depression, he would have qualified for assisted suicide and would surely have found a doctor who would agree to his request.

Since the Oregon law, using guidelines like those in effect in the Netherlands, does not require an independently referred doctor for a second opinion, he would have been referred by a physician supportive of assisted suicide to a colleague who was equally supportive. The evaluation would very likely have been pro forma. He could have been put to death in an unrecognized state of terror, unable to give himself the chance of getting well or of dying in the dignified way he did.

Although the Oregon law requires counseling if the patient has a mental disorder or has his or her judgment impaired by depression, it is the doctor who determines whether such a referral is indicated. The evidence indicates that most doctors are not

qualified to make such a determination (Conwell & Caine, 1991).

Nor should psychiatrists and psychologists be sanguine at being reduced to the role, advocated in most legalization proposals, of simply determining if a patient is competent to make a decision regarding euthanasia. It was the fact that I was not the arbiter of this case that permitted the patient I described with acute myelocytic leukemia to talk freely about his fears of death and eventually to change his mind about wanting an immediate end to his life.

Neither legalization of euthanasia nor opposition to it constitutes a public policy that addresses the larger problem of how to care for the terminally ill. The call for legalization is a symptom of our failure to develop a better response to death and the understandable fear of artificial prolongation of life (Hendin, 1994b).

Yet the dangers threatened by legalization of assisted suicide can be avoided. They are being avoided elsewhere in western Europe where there is no great demand for legalizing assisted suicide or euthanasia. Care for the terminally ill is better in the Scandinavian countries than in the United States and in the Netherlands. Scandinavian doctors do not accept excessive measures for prolonging life in people who are virtually dead, but neither do they encourage people to choose death prematurely.

There is a great deal of evidence that in the United States as in the Netherlands doctors are not sufficiently trained in the relief of pain and other symptoms in the terminally ill. Hospice care is in its infancy in both countries. We have not yet educated the public as to the choices they have in refusing or terminating treatment that prolongs a painful process of dying. And we have not devoted enough time in our medical schools to educating future physicians about coming to terms with the painful truth that there will be patients they will not be able to save but whose needs they must learn to address.

Psychiatrists and psychologists in the Netherlands played a relatively passive role in the growing normalization of suicide

and euthanasia even though this has meant that patients who are basically suicidal, whether physically ill or not, are being assisted in death like those who seek relief in the last days of a terminal illness. We should learn from that experience to be more involved, educating the public that legalization may become a license to abuse and exploit the fears of the ill and depressed. Legalization accepts the view of those who are engulfed in suicidal despair that death is the preferred solution to the problems of illness, age, and depression. It encourages the worst tendencies of depressed patients most of whom can be helped to overcome their condition. "Normalizing" suicide as a medical option along with accepting or refusing treatment, inevitably lays the groundwork for a culture that will not only turn euthanasia into a "cure" for depression but may prove to exert a coercion to die on patients when they are most vulnerable.

REFERENCES

- Borst-Eilers, E. (1992). Euthanasia in the Netherlands: brief historical review and present situation. In R. I. Misbin (Ed.), *Euthanasia: The Good of the Patient; The Good of Society*. Frederick, Maryland: University Publishing Group.
- Brown, J. H., Hentleff, P., Barakat, S. & Rowe, C. J. (1986). Is it normal for terminally ill patients to desire death? *American Journal of Psychiatry*, 143, 208-211.
- Chabot, B. E. (1993). *Zelf Beschikt*. Amsterdam: Uitgeverijbalans.
- Conwell, Y. & Caine E. D. (1991). Rational suicide and the right to die: reality and myth. *N. Engl J Med*, 15, 1100-1103.
- Gomez, C. (1991). *Regulating Death: Euthanasia and the Case of the Netherlands*. New York: The Free Press.
- Gevers, J. K. M. (1992). What the law allows: legal aspects of active euthanasia on request in the Netherlands. In R. I. Misbin (Ed.), *Euthanasia: The Good of the Patient, the Good of Society*. Frederick, Maryland: University Publishing Group.
- Hendin, H. (1995) *Suicide in America*. New York: W. W. Norton and Co.
- Hendin, H. and Klerman, G. (1993) Physician-assisted suicide: the dangers of legalization. *American Journal of Psychiatry*, 150, 143-145.
- Hendin, H. (1994a). Seduced by death. doctors, patients and the Dutch Cure. *Issues in Law and Medicine*, 10, 1-45.
- Hendin, H. (1994b) Scared to death of dying. *The New York Times Op-Ed*, December 16, 1994.

- K. A. Productions (1993). "An Appointment with Death" (film).
- Koerselman, G. F. (1994). Balanssuicide als mythe: over 'Zelf Beschikt,' door B. E. Chabot MGv 5, 515-527.
- KNMG, *Standpunt Inzake Euthanasie* [Standpoint on Euthanasia], 31 Medisch Contact 990 (1984), published in abridged form in KNMG, Guidelines for Euthanasia, 3 Issues in *Law and Medicine* 429 (1988) (Walter Lagerwey trans.).
- President's Commission for the Study of Ethical and Biomedical and Behavioral Research, *Decisions to Forego Life-Sustaining Treatment* (1983).
- Schudel, W. J., Nolen, W. A., van Dijk, W. R., & Su-
torius, E. (1993). *De Zaak van de Vasthoudende Inspecteur*. Maandblad voor Geestelijke Volksgezondheid, 738-749.
- Thomas, L. (1980). Dying as failure? *Journal of American Political Science*, 444, 1-4.
- van der Maas, P. J., van Delders, J. J. M., & Pijnenborg, L. (1991). Euthanasia and other medical decisions concerning the end of life, *Lancet*, 338, 669-674.
- van der Maas, P. J., van Delders, J. J. M., & Pijnenborg, L. (1992). Euthanasia and Other Medical Decisions Concerning the End of Life. *Health Policy Monograph*. New York: Elsevier.

Mr. CANADY. Thank you, Dr. Hendin.

Let me just follow up on Dr. Hendin's testimony with a question for Dr. Quill.

Dr. Quill, do you think doctors should introduce the idea of the physician-assisted suicide to terminally ill or disabled patients?

Dr. QUILL. One of the safeguards that has been suggested is that this idea should always come from the patient. This is not part of physicians initiated possibilities.

Mr. CANADY. You think that sort of conduct on the part of physicians should be prohibited.

Dr. QUILL. Absolutely it should. But when a patient raises it, I think we all agree, we need to discuss it with them. Rather than saying "yes" or "no" without full understanding, it should be the beginning of an exploration. It should be viewed as a cry for help, and the job of the clinician is to figure out what that really means. It might be under treated pain, it might be unrecognized depression, it might be many other things, and it might be that they have really reached the end of the rope.

Mr. CANADY. Let me ask you another question. In 1991 you wrote about providing the means for a terminally ill patient with leukemia for ending her life. You talked about assisted suicide as a last—as a rare "last resort" for the terminally ill.

In 1992 you wrote that assisted suicide should also be available to people with—and I quote—"incurable but not imminently terminal, progressive illnesses such as ALS or MS. But you still oppose legalization of active euthanasia where doctors give lethal injections to their patients, because of the risk of abuse it presents."

Then in 1994 you dropped the reference to "progressive" illness, allowing assisted suicide for "incurable, debilitating illnesses;" in other words, for physical disabilities. You said we must allow lethal injections by physicians, or we would "unfairly discriminate against patients with unrelievable suffering who resolve to end their lives but are physically unable to do so."

We have heard talk about the slippery slope. I would suggest to you that the progress of your own views on this subject and your comments on this subject illustrate the danger of the slippery slope. I think you have been sliding down the slippery slope.

What would your response be to that?

Dr. QUILL. I realize in the world of politics you have to take a position then defend it forever. These are explorations—

Mr. CANADY. It doesn't always happen that way.

Dr. QUILL. These are exploration of ideas about this. I am, in fact, interested in good care for dying people, good care for people who don't have many choices. I am willing to explore these issues at an intellectual level to try to see what might work and what the implications are.

When we get down to the level of creating public policy, which is where we may be now if these court decisions stand, then I think we have to take a hard look at all of these issues, look at each of these questions in a very careful way.

My own belief is that right now, given the state of our health care system, that we should restrict this practice as the last resort for terminally ill patients. The other elements of the health care system are too volatile right now.

Mr. CANADY. So let me see if I understand. What is your current position? What should be allowed, and what should not be allowed?

Dr. QUILL. My current position: This is allowable for terminally ill, competent patients as a last resort when good palliative care fails.

Mr. CANADY. You have gone back to your 1991 position as opposed to what you expressed in 1992 and 1994.

Dr. QUILL. I think for the current situation, yes.

Mr. CANADY. OK.

Dr. Klagsbrun, you appeared on a debate in CNN in April and you stated, "I am not interested in being placed in the same category as Dr. Kevorkian." What did you mean by that? Why don't you want to be affiliated with Dr. Kevorkian?

Dr. KLAGSBRUN. My criteria for participating in helping someone die includes, as I said in my testimony, the requirement that I get to know the patient's circumstances extremely well over a long period of time.

There is no emergency, in my mind, to help a patient die. It can be done thoughtfully and carefully, having met the criteria that Dr. Quill has outlined and others, and, to the best of my knowledge, Dr. Kevorkian does not fit those criteria.

The other piece is that at this present time I also feel strongly that I want to limit this exploration and put in the safeguards for people who are terminally ill and not apply this ruling to people who are incompetent.

Mr. CANADY. Thank you. Dr. Hendin.

Let me follow up on that and ask you how the standards established in the Netherlands for assisted suicide compare with the standards set forth by Dr. Quill and Dr. Klagsbrun and others in this country?

And without objection, I give myself 3 additional minutes.

Dr. HENDIN. The law that was passed in Oregon and became a model that other States are considering has all of the limitations that the Dutch system does with regard to voluntariness, competence, consultation. They are as flawed and would have the same result as happened in the Netherlands.

As far as what Dr. Quill and Dr. Klagsbrun are proposing, it is a little unclear to me. I had heard Dr. Quill as saying that he is taking his position as basically a political position, because he and most people know that it is harder to get people to favor euthanasia than assisted suicide. And in the Netherlands that is the solution that they came to, to fight for assisted suicide first.

But addressing it as he presented it today, to fight for safeguards, the only safeguard that he provides—and by the way, the issue that you raised with him about his positions in the past, he has said that he has feared legalized euthanasia because of the inequities in medical care. Those surely haven't changed in the last two or three years. But he is proposing today, as I understand it, a palliative care consultant. Dr. Klagsbrun also said that he wants a palliative care consultant, but it is interesting in his own case he chooses Dr. Foley, who will not put him to death under any circumstances.

Dr. KLAGSBRUN. I will negotiate that with her then.

Dr. HENDIN. I think he made the wise choice.

But the problem with the palliative care consultant is that it is actually a step backward. The Dutch are now using more and more palliative care consultants, but they are not getting the Kathy Foleys as palliative care consultants; they are getting people with the orientation more of Dr. Quill. A minority of palliative care people perform euthanasia and they end up accumulating a large majority of the cases.

I interviewed one doctor who had done 100 cases and another over a thousand. Those people very seldom find cases in which they do not think assisted suicide or euthanasia is a solution. Having a specialist increases the danger, and it works against what Dr. Klagsbrun wants, which is people that know the patient a long time. That may be possible in some places, but it surely is not possible in the United States where most people—Dr. Klagsbrun may have a doctor he knows a long time. Most doctors I know do. Most of my friends who are not doctors do not have physicians of their own that they have known a long time. It is not the way medical care currently exists in this country.

In the Netherlands, where they boasted that they have a family physician who will make the decision, the family physician usually doesn't see it as appropriate, so the euthanasia advocates have found ways to circumvent the family physician. They had traveling physicians going around the country who would consult with families who felt patients should die where the family doctors didn't support the decision. It became a scandal. These doctors were referred to as angels of death, and the scandal was such that now only lay people do the traveling but the attempt is the same to get around the family physician.

And by the way, apropos of Dr. Klagsbrun's criteria that the doctor should suffer while he is performing euthanasia, my experience with the Dutch doctors is that they do suffer the first time. By the 10th they suffer less, and by the 50th they don't suffer at all, and that is the danger of giving people the power to end other people's lives; that callousness sets in. They begin with a certain element of conscience; after a while there is an enormous need to justify what they are doing.

Mr. CANADY. Mr. Frank.

Mr. FRANK. Ms. Coleman, the point I want to start with is your very important point that we start out in an unequal standpoint in terms of access to care. If we were to abolish the Federal medic-aid program as it is currently constituted and returned it to the States, would that change your opinion any?

Ms. COLEMAN. I believe that turning health care even further over to the States than it is currently would be harmful to people with disabilities. States already, for example, are required to provide and cover nursing home services within limits they get to define, but they are all given the option about providing in-home support services.

In the assisted suicide cases, many of the individuals who were quadriplegic that have been ruled terminally ill were confined to nursing homes, so that is a very key issue and right now one of States rights, and we feel that there is an even greater risk in broadening States rights in the area of long-term services.

Mr. FRANK. Dr. Foley, would you have an opinion on the changes being proposed in Medicaid? You also spoke of the problem of unequal access to care in the context in which the decisions are being made.

Dr. FOLEY. The reason why many minorities are not cared for in hospice programs is because they don't have a primary care physician. Their care comes in emergency rooms. They don't have a primary care physician to continue their care in hospice programs. That right there would suggest that this would influence—

Mr. FRANK. Would abolishing the Federal Medicaid program make that worse, in your judgement?

Dr. FOLEY. The evidence is that abolishing it would make it enormously worse. In New York State at the present time, the significant problems that my patients are facing who are dying at home without primary caregivers, therefore not counted eligible for hospice, are having their home care aides removed from them, forcing them into services of care—

Mr. FRANK. To save money on these terrible entitlement programs.

Dr. FOLEY. The greater issue is that these patients do not have care currently paid for under Medicaid, and more importantly they do not have their pain medications paid for, and they can't afford the cost of their—

Mr. FRANK. Under Medicare. So that—

Dr. FOLEY. These are major programs that are dramatically economically influencing patients' decisions because they have no other options.

Mr. FRANK. I appreciate those points, but obviously we have a different issue about suicide. But what we would like to do is to absolutely minimize the point at which people reach that. And it does seem to be clear on the one hand to be very compassionate toward those faced with the pressures that may lead them to contemplate suicide is very admirable, but to beat up these terrible entitlement programs, Medicaid and Medicare, and talk constantly about cutting them back to balance the budget, we ought to be clear that does far more harm, it seems to me, to these victims than we might do otherwise.

Ms. Coleman you make a good point about the discrimination. I believe, I haven't checked this recently, but in many States unassisted suicide is still a crime; that someone who tries to commit suicide and fails is legally vulnerable. Is that no longer the case?

Dr. HENDIN. No longer.

Mr. FRANK. Do you agree that people should have the right as an individual to commit suicide? Does anyone disagree with that?

Dr. HENDIN. I do. I would not say they have the right. There is a difference between the State not doing something to punish somebody for doing an act and the State calling it a right, which gives this a sanction.

Mr. FRANK. That is a distinction without a difference. You leave me alone, and I do what I want, and that is OK. People legally should be allowed to kill themselves if they are driven to do that without any fear of adverse legal consequences either to themselves or their estates. That is why it doesn't seem to be totally discriminatory.

This is a tough issue, but if I am legally entitled—put it that way—legally entitled to commit suicide without adverse legal consequences, and I become physically incapable of doing it, then it seems to me to say that in those limited circumstances I can get someone else to help me and share with them my immunity to legal action is not discriminatory. You can say in practice it wouldn't work that way, but that is a theoretical justification for that situation.

Ms. COLEMAN. I would like to respond to that. I need to begin by saying that the first case that I became involved in was in 1985 when Elizabeth Bouvia, a woman with cerebral palsy, sought assistance from the ACLU to starve herself to death with the benefit of a morphine drip in a hospital. I was in Los Angeles at the time, and the ACLU claimed that she would not be able to kill herself physically; however, that is incorrect. As a physical matter she could have done so. There are a lot of presumptions that people with disabilities are incapable, but we are not.

Mr. CANADY. The gentleman will have 3 additional minutes.

Mr. FRANK. I realize that, but it is important if we are going to deal with this to make a distinction between people saying if you could construct an ideal situation, I would allow it, but I believe that practical difficulties would always intervene, and saying even if you could get to a situation where it would be safeguarded, I would not allow it, and that is where I am trying to get at. You can find situations, but there are clearly situations where people would not be physically capable but could ask for it.

Let me ask everybody, let me ask the three who oppose physician-assisted suicide, I understand your view that in practice it will never be possible to have uncoerced decisions, but if it were, if it were theoretically, would you still object to someone who had made the decision that he or she wanted to die and was physically incapable of committing the act himself or herself, would you still object to someone having a legal immunity to help them?

Dr. HENDIN. I think they are two different issues. I mean, there is a lot.

Mr. FRANK. Just answer the one. Theoretically if we could get the safeguards, are you opposed in principle to allowing one person to help—

Dr. HENDIN. It is more than that.

Mr. FRANK. If you don't want to answer the question, I will ask somebody else.

Dr. HENDIN. What I would say is if I were persuaded that the only way to help the terminally ill would be through that, I would consider it.

Mr. FRANK. That is not my question. You are an intelligent man. You know that is not my question. People say let's not get political. I agree. The question is if it were not the only way to help that person. You changed the question. I as an individual decide, and I can contemplate circumstances in which I would ask someone else to help me do that for myself. If I as an individual decided that that is what I wanted and had the right to do it myself, but I lost the physical capacity to do it myself, could I ask anyone else to help me?

Dr. HENDIN. You could, but I would oppose the State giving sanction to that.

Mr. FRANK. By "sanction" do you mean criminal sanction? I am not looking for the Congressional Medal of Assisted Suicide. I am talking about an immunity from prosecution.

Dr. HENDIN. I don't think you have the right to involve another person and have government sanction for that.

Mr. FRANK. As a theoretical matter would I have a right?

Ms. COLEMAN. In a very futuristic society in which all forms of oppression are ended, in which the opportunities that Dr. Foley offered are fully available, and I mean all kinds of oppression are ended, then I would say it is time that we could talk about offering physician-assisted suicide to anyone who requested it. But discriminating against a class of people on that basis I would have to continue to object to.

Mr. FRANK. I would allow more than that. You are saying that your objections are for the current situation. Things are so unequal, you don't think it would be a choice.

Ms. COLEMAN. Not in my lifetime.

Dr. FOLEY. I don't think this is the question you should be asking people.

Mr. FRANK. I understand that there are a lot of things that I would like to do that you have made it clear that you would not like to help me with. I understand you do not think it should be the one, but it was.

Dr. FOLEY. So that means that—

Mr. FRANK. I take it, Dr. Foley, that you think it is more difficult to answer than you want to, and I am disappointed in that. This is a tough set of issues.

Mr. CANADY. The gentleman will have 1 additional minute.

Dr. FOLEY. I would like to answer the question. And the way I would like to answer the question is what we really need to be addressing is what is clinically pragmatic and possible for people to allow them to have that discussion.

I disagree very strongly with Dr. Quill that we should not bring up physician-assisted suicide or suicide with patients. I think we should broadly discuss the—

Mr. FRANK. Dr. Foley, that is not my question. My question is I am trying to understand whether or not we are talking about something which is a philosophic, in some cases a religious-based, objection, which has one set of objections, or it is one that is practical. I realize that given the real world, the objections will still be there, but there is an intellectual, distinguishable question.

Dr. FOLEY. If you would let me finish my answer, if you look at the way the Government has responded to those who have assisted in suicide in this country, it is with very, very minimal legal restrictions. Many of the people get community service, they get a variety of other treatments. The way we are currently acting is that the Government is, in fact, accepting it.

Mr. FRANK. That is not an answer to my question. The description of what the Government does is not an answer to what you think it should be. And I would say in closing, if you want it to be not legally sanctioned, then we ought to do that honestly. Say-

ing that it is against the law and then winking at the law seems to me to be an unfortunate situation.

Mr. CANADY. Mr. Hyde.

Mr. HYDE. Thank you.

I have not heard any discussion about the various methods of assisting someone dying. Withholding treatment is one thing. Taking an affirmative action such as a deadly injection, an air bubble in the veins or some other way, it seems to me substantively different. Are they the same? Are they different? Does anyone think they are the same—withholding treatment as against a direct action?

Dr. Quill.

Dr. QUILL. They are not the same, but there are similarities. If you take someone who is making a decision to stop life supports as an example, like dialysis machine or breathing machine, it is a very complex and difficult question, because when people stop those treatments, they die. From a clinical point of view, it is a very, very similar, if not the same question. We need the same kinds of safeguards for those activities because people die when you stop those treatments.

We actually conduct those decisions, withholding, withdrawing life sustaining treatment, right now out in the open. We get consultations when somebody is considering that from our psychiatric colleagues and other experienced people. The best minds work together to try to decide—

Mr. HYDE. But there is a difference in kind. When you withhold nourishment from somebody, you make them comfortable, you alleviate their pain, and you just don't give them nourishment as against coming in and injecting a deadly whatever into them. Aren't those different acts?

Dr. QUILL. They are different, but it depends on whose perspective you are taking. I think from the professional perspective they are different. From some ethical perspectives, they are different. From a patient who is in one of those bad situations, it is—

Mr. HYDE. The result is the same: You die. But we are all dying anyway.

Dr. QUILL. Don't devalue the situation these people find themselves in. They are genuinely desperate, and I think we all agree that they are in a bad situation.

Mr. HYDE. I don't devalue it, I can assure you. I have lived through it. I would never devalue it.

Dr. QUILL. Then you know even if we decide this should not be available, which we may decide, we then have to decide how will we deal with this situation. What should we do if palliative care is not effective?

Mr. HYDE. I am just suggesting that when a doctor comes in and gives you an injection that kills you, that that is, to my mind, much more dehumanizing than withholding treatment. Although ultimately the end is the same. But after all, that is where we are headed anyway.

Ms. COLEMAN. The precedents upon which the second and ninth circuit courts were based, if you read the prior cases, continuously indicated that there is a very important legal difference between active and passive measures to hasten death. And now that those courts summarily have set aside the distinction and proceeded with

the legalization or declaring a constitutional right, also in the context of those cases where they involve people with severe but non-terminal disabilities, that was offered as one of the safeguards that would be in place when it was still debatable whether someone like Christopher Reeve could pull the plug on his ventilator.

In the past it took a year or two to hold a court case to decide, and in a couple of cases the disabled community was able to get to the individual and cause them to realize that it is time to get past your suicidal despair. Now those safeguards are not in place. The cases are not public. We are not able to reach anyone. And especially they are not being studied in terms of the effects of withdrawal, and I think that is something that study needs to happen before we begin to go beyond the line that was previously drawn.

Mr. HYDE. As this becomes more thinkable—and it certainly is, we are thinking about it today, maybe 5 years ago we wouldn't—but as assisted suicide becomes more and more thinkable, the question of the duty to get out of the way of your children—because we all know so much money is spent during the last few years of life, the last few months of life, and the patient begins to feel guilty depriving the children, the grandchildren, of whatever it is you are depriving them of by paying the hospital and the nursing home.

And the pressures, it seems to me, as this becomes more acceptable, thinkable, to get out of the way, to vindicate Governor Lamm of Colorado, will be enormous.

E.J. Dionne of the Washington Post wrote recently: "What easier way to cut costs than to create subtle pressures on patients to kill themselves? Of course, there is no managed care plan out there that would ever do such a thing consciously"—wait, Mr. Dionne—"one hopes so anyway. But as medical care for the very ill becomes more and more expensive, it is naive to pretend such pressures will never arise."

Mr. CANADY. The gentleman will have 3 additional minutes.

Mr. HYDE. I have come across an article by an economist named K.K. Fung, F-U-N-G, "Dying for Money: Overcoming Moral Hazard and Terminal Illnesses through Compensated Physician-Assisted Death." This was in the American Journal of Economics and Sociology. And he says here: "But by offering the right to die with dignity, an escape valve to the current fiscal overcommitment and concomitant human suffering is created. The Government could convert the entitlements into a death benefit equivalent to, say, 60 percent of the projected medical or nonmedical payments which the terminally or chronically ill would have received if they had chosen to die a slow death"—we are all dying a slow death, by the way, as I see it. "The stigma of dying for private gain can be reduced. The stigma of dying for private gain can be reduced by specifying that at least half of the converted benefits must be devoted to public charity."

How thoughtful. As these ideas become more and more prevalent, I can see one's hospitalization, if one is lucky enough to approach George Burns, as being a very uncomfortable time. Won't legalization of assisted suicide encourage HMO's and insurers to give incentives to doctors and patients to pursue assisted suicide?

Dr. Quill.

Dr. QUILL. Let me, just as food for thought, tell you what happened in Oregon since they passed this referendum in Oregon legalizing physician-assisted suicide. It is still under appeal in the courts. What has happened in the fallout is not a rush to assisted suicide. All of the sudden the university hospital has found funding which they never had before for palliative care consultants. Managed care organizations are talking much more about including palliative care as a benefit for everybody because they want to be sure that nobody chooses this option without having adequate palliative care. There is much more energy being utilized and resources unearthed for palliative care than ever before in that State.

Palliative care—

Mr. HYDE. So, the more available that this becomes, the more sensitive we are going to become to not using it?

Dr. QUILL. The more serious we are going to be about listening carefully to what dying patients are telling us, which is that they are scared. They are scared that they will not have health care, they are scared that they won't have adequate palliative care pain relief, and they are scared even in the face of adequate health care and palliative care, if they get in a tight spot, that we will be too afraid to help them. And this is opening up that dialog more. Whether or not we are going in the right direction in terms of policing, the dialog is deepening.

Mr. HYDE. I am kind of out of time, but maybe in the next round.

Mr. CANADY. Yes, we will do another round.

Let me follow up on that question. Dr. Foley, would you like to respond to that same subject?

Dr. FOLEY. I think Dr. Quill and I agree on many different areas, and we disagree at how we settle the issues. I think that clearly by having this discussion and having this debate, we can let the American public know that they have the right to refuse treatment; that they have the right and that physicians can withhold care and withdraw care.

But there have been innumerable surveys that the public doesn't know that they have the right to refuse treatment, and that physicians don't know what are the appropriate ways to withhold or withdraw care. We have this incredible lack of knowledge that is ongoing that is driving and encouraging part of this debate.

I think that physicians are, in fact, not well-equipped to care for the dying and not supported to do so. And going back to this educational issue, it is very much along the lines that we need to provide them with education, but we are so far from that, to be able to move in this direction at this time would be inappropriate to patients because physicians haven't had the opportunity to care for the dying, to learn how to do it, to look at what these issues are, and to just see how small a number of patients we are beginning to address.

I think the last issue is—we haven't even focused on this—and that is the issue of patient-physician trust. This is really a very, very critical issue. There are again numerous surveys that show that the American public trust of their physicians is eroding. If they do not trust their physicians to care for them, why in any way would they trust them to kill them?

Even all of the other issues that are currently happening. I think this needs lots of discussions and lots of hearings. You have a responsibility to look at what the legal barriers are in States, to look at the barriers and ask the public what the issues are so that we can have this in an open way so that we learn how to improve the care to the dying.

Mr. CANADY. Dr. Hendin.

Dr. HENDIN. I would like to comment on that. I think the debate about where we should go certainly has mobilized people who are interested in palliative care to try to influence the managed care companies. I am involved in that myself, trying to have an impact that we provide care for people who are terminally ill.

On the other hand, I think that is driven by our fear that unless we provide that care, then the people who are in favor of euthanasia like Kevorkian, will seem to be the only people who are the advocates for people who are terminally ill, and that is the point that everybody here was making.

On the other hand, one thing I will predict, that if legislation comes, what will happen is what happened in the Netherlands. Once you have it, palliative care will be the first casualty of legalized assisted suicide and euthanasia. That is what happened there. There was enormous interest in the debate. When you get into discussions with doctors, you don't hear them talking like Kathy and Tim are talking. It is constantly how can you extend euthanasia to more and more patients; that is, it becomes the easier and easier solution.

In the climate now certainly there is a climate for debate and discussion, and it may be that out of it will come something good. The one thing that may come good is that everybody will focus on improved palliative care. But if the Netherlands is any example, if legislation occurs here it will have the reverse effect. The Netherlands is not leading the world in palliative care; it is trailing.

Ms. COLEMAN. Managed care companies are already restricting care even knowing that it could result in death. Two weeks ago I spoke to a psychiatric social worker friend of mine at a Los Angeles hospital, who reported that against medical and psychiatric advice, the managed care company instructed the facility that they would not cover any further care after 72 hours for a particular individual, who then went home and committed suicide as she said he would.

I don't think that managed care companies are at all hesitant on this topic area, and I very much doubt the reasoning that was just given for expanding coverage for palliative care. The likelihood is that they see it as a cost savings over more aggressive measures.

Mr. CANADY. We will conclude with that. I want to thank each of you for taking the time to be with us. Your testimony has been very helpful to us.

We will now move to our second panel. The first witness testifying on our second panel today will be Dr. Charles Krauthammer. Dr. Krauthammer is a syndicated columnist for the Washington Post and a regular panelist on Washington's highest rated political talk show, "Inside Washington." He came to Washington in 1978 as a science advisor to the Carter administration.

Next we will hear from Barbara Coombs Lee. Ms. Lee was the chief petitioner for Oregon's Death with Dignity Act, which was passed by citizens' initiative in November of 1994.

Next to testify will be Prof. Yale Kamisar. Professor Kamisar is the Clarence Darrow Distinguished University Professor at the University of Michigan Law School. He has written and spoken extensively on the topics of assisted suicide and euthanasia.

Following Professor Kamisar will be Prof. Charles Baron. Professor Baron is a professor of law at Boston College Law School, where he has taught and written in the areas of constitutional law and bioethics.

The final witness on the second panel will be Prof. Victor Rosenblum. Professor Rosenblum is the Nathaniel L. Nathanson Professor at the Northwestern University School of Law. He has written numerous articles dealing with constitutional administrative law. Currently Professor Rosenblum is serving as visiting professor to Arizona State University College of Law.

We thank you all for being here with us today. Without objection, each of your statements will be made a part of the record, and I would ask that each of you attempt to summarize your testimony in no more than 5 minutes.

Dr. Krauthammer.

STATEMENT OF CHARLES KRAUTHAMMER, M.D.

Dr. KRAUTHAMMER. Thank you, Mr. Chairman.

Let me begin by thanking you and the committee for inviting me to testify on a question that is of grave national importance as the issue of physician-assisted suicide.

As you indicated within the last 2 months, two U.S. appeals courts have struck down as unconstitutional laws banning physician-assisted suicide. In my view, these are the most morally laden judicial decisions since *Roe v. Wade*, and they raise two important questions: One, should physician-assisted suicide be permitted; and two, should judges be deciding the issue?

I understand that the first question is properly the province of another panel, but since the committee has seen fit to ask a physician to sit on this judicial panel, permit me to give you my personal view as someone who himself took the Hippocratic Oath 21 years ago, swearing that I would give no deadly medicine to anyone if asked.

I believe that permitting doctors to kill their patients is a dangerous and pernicious idea, however compassionate the motive. The erosion of the taboo against physician-assisted suicide would inevitably lead to abuses, and this is not a hypothesis. As was indicated on the earlier panel, it has been tested in Holland and proved a fact. Holland is the only jurisdiction in the West that now permits physician-assisted suicide.

The practice is now widespread and abused. Indeed, legalization has resulted in so much abuse, not just psychological pressure on the ill and the elderly, but a shocking number of cases of out and out involuntary euthanasia, the defenseless patients simply put to death without consent, that last year the Dutch Government was forced to change its laws on euthanasia.

Judge Robert Miner, writing for the second circuit court, uncomprehendingly admits this fact. He writes that some physicians in the Netherlands practice involuntary euthanasia, although it is not legal to do so.

Well, why would such things occur in the Netherlands? Are the people there morally inferior to Americans? Of course not. The obvious reason is that once the absolute ethical norm established since the time of Hippocrates that doctors not kill was removed in the name of compassion, the inevitable happened. Good ordinary doctors, in their zeal to be ever more compassionate in terminating useless and suffering life, began killing people who didn't even ask for it. Once given the power hitherto reserved to God, some exceeded their narrow mandate and began acting like God.

This should be no surprise, nor should be there any illusion that what occurred in Holland would occur here. But whatever my private opinion and those of the robed eminences on the second and the ninth circuits, is this not an issue which democratic peoples ought to decide for themselves?

Mr. Chairman, the question, I believe, is have these judges learned nothing from the *Roe* decision? The United States is the only country in the Western world that has legalized abortion, not by popular vote, not by legislative action, but by judicial fiat. The result has been a quarter century of social and political turmoil. As Ruth Bader Ginsburg has written: "*Roe v. Wade* seemed entirely to remove the ball from the legislators' court. . . ." And has "halted a political process that was moving in a reform direction and thereby, I believe, prolonged divisiveness and deferred stable settlement of the issue."

Having disenfranchised a democratic people on one of the fundamental and moral issues of our time, the courts are now intent, it seems, on doing it again. There is not a single country in the West, again except Holland, that permits doctors to help their patients kill themselves, and now judges have decreed that the United States is such a country, will be such a country, indeed, that the Constitution demands that the United States be such a country.

And it is not as if the people have neglected this issue. Two years ago a New York State task force of doctors, bioethicists and religious leaders organized at the request of Governor Cuomo concluded unanimously that laws prohibiting assisted suicide and euthanasia should not be changed. Moreover, within the last 5 years, three States have held referenda on the question. California and Washington voted narrowly to retain the ban. Oregon voted even more narrowly to lift it.

Well, they can forget their votes because the ninth circuit has decided the issue for them, proclaiming a constitutional right to die lodged undiscovered all these years in the liberty interest of the 14th amendment.

The ninth circuit draws courage and precedent from the Supreme Court's *Casey* decision reaffirming the right to abortion on the grounds that matters, "involving the most intimate and personal choices a person can make in a lifetime, choice essential to personal dignity and autonomy, are essential to the liberty protected by the 14th amendment."

Well, reasoned the ninth circuit, if the right to abortion is central to personal dignity and autonomy, why not suicide for the terminally ill? But by that logic, why stop with assisted suicide? Why should the State be allowed to interfere with drug taking? And as to the right to assisted suicide, why stop with the terminally ill? Under what principle should the nonterminally ill or even the healthy be denied the autonomy of assisted suicide? Take the inconsolably bereaved parent who has lost his children in a disaster, or the severely disabled whose life is a living hell. Why deny them the right under this autonomy logic to assisted suicide? Why deny it to anyone who has had enough of life?

The second circuit decision, I think, is equally disturbing. It finds its mandate not in the liberty interest, but in the equal protection clause of the 14th amendment. It argues that in the *Cruzan* case, the Supreme Court appears to establish the right of the terminally ill to refuse life-supporting medical treatment. It is therefore unconstitutional discriminatory, in the opinion of the Court, to deny terminally ill patients not on life support the equal right to kill themselves. If the doctor can pull the plug, why can he not be allowed to prescribe hemlock? Judge Miner writes: "Physicians do not fulfill the role of killer by prescribing drugs to hasten death any more than they do by disconnecting life support systems."

I believe, Mr. Chairman, that this is pernicious nonsense. There is a great difference between not resuscitating a stopped heart, allowing nature to take its course, and actively killing someone. In the first instance, the patient is dead; in the second he only wishes to be dead. And in the case of a life sustained by artificial hydration or ventilation, pulling the plug simply prevents elongation of a dying process; prescribing hemlock initiates it.

Mr. Chairman, in conclusion let me say that the circuit court decisions on assisted suicide, I believe, represent a high point in judicial arrogance. To quote the dissent of Judge Andrew Kleinfeld on the ninth circuit, "that a question is important does not imply that it is constitutional." The Founders didn't establish the United States as a democratic republic so that elected officials could decide trivia while all the great issues were decided by the judiciary.

Mr. Chairman, I have no great expectation that over the long run the people and their legislatures would hold the line against the physician-assisted suicide, but I would rather see the ban overturned by popular will after rigorous debate than by judicial fiat. If the consequences of permitting physician-assisted suicide are as evil as I predict, the democratic decision can always be reversed. But with constitutional rights there is no further appeal. The debate ends. And as with abortion, all that is left is bitterness, angry demonstrations, and a deep sense of disenfranchisement. Having done this once, are we going to do it again?

Thank you, Mr. Chairman.

Mr. CANADY. Thank you, Dr. Krauthammer.

[The prepared statement of Dr. Krauthammer follows:]

PREPARED STATEMENT OF CHARLES KRAUTHAMMER, M.D.

Good afternoon, Mr. Chairman. Let me begin by thanking you, Chairman Canady, Congressman Frank and the committee for inviting me to testify today. It is an honor to address you on a question as gravely important to the moral and constitutional life of this country as physician-assisted suicide.

Within the last two months two U.S. appeals courts have struck down as unconstitutional laws banning physician-assisted suicide. In my view, these are the most morally laden judicial decisions since Roe v. Wade. They raise two questions: (1) Should physician-assisted suicide be permitted? And (2) Should judges be deciding the issue?

I understand that the first question is properly the province of another committee panel. But since the Committee has seen fit to ask a physician to sit on this judicial panel, permit me to give you my personal view as someone who himself took the Hippocratic oath some 21 years ago, swearing, as generations of physicians swore before me, "I will give no deadly medicine to anyone if asked."

I.

Permitting doctors to kill their patients is a dangerous, pernicious idea, however compassionate the motives, principally because the erosion of the taboo against physician-assisted suicide will inevitably lead to abuses.

This is not a hypothesis; it has been tested in Holland and proved a fact. Holland is the only jurisdiction in the Western

world that now permits physician-assisted suicide. The practice is now widespread (perhaps 2000-3000 cases a year; the US equivalent would be 40,000-60,000) and abused. Indeed, legalization has resulted in so much abuse -- not just psychological pressure but a shocking number of cases of out-and-out (ital) involuntary (unital) euthanasia, inconvenient and defenseless patients simply put to death without their consent -- that last year the Dutch government was forced to change its euthanasia laws.

Judge Roger Miner writing for the 2nd Circuit uncomprehendingly admits the reality of this nightmare: "It seems clear that some physicians [in the Netherlands] practice non-voluntary euthanasia, although it is not legal to do so." Well, why would such things occur in the Netherlands? Are the people there morally inferior to Americans? Are the doctors somehow more cruel and uncaring?

Of course not. The obvious reason is that doctors there were relieved of the constraint of the law. The absolute ethical norm established since the time of Hippocrates that doctors must not kill was removed in the name of compassion, and the inevitable happened. Good, ordinary doctors in their zeal to be ever more compassionate in terminating useless and suffering life, began killing people who did not even ask for it. Once given power heretofore reserved for God, some exceeded their narrow mandate and acted like God. There should be no surprise -- nor any illusion that what occurred in Holland will not occur here.

But whatever my private view and whatever the private view of the robed eminences of the 2nd and 9th Circuits, is this not an issue which a democratic people ought to decide themselves?

Have these judges learned nothing from *Roe v. Wade*? The United States is the only country in the Western world that has legalized abortion not by popular vote or legislative action but by judicial fiat. The result has been 25 years of social and political turmoil. As Ruth Bader Ginsburg has written, "*Roe v. Wade*...seemed entirely to remove the ball from the legislators' court." It thus "halted a political process that was moving in a reform direction and thereby, I believe, prolonged divisiveness and deferred stable settlement of the issue."

Having disenfranchised a democratic people on one of the fundamental moral issues of our time, the courts are now bent on doing it again. Not a single country in the world (save Holland) permits doctors to help patients kill themselves. Now judges have decreed that America will be such a country, indeed that the constitution demands that America be such a country.

It is not as if the people have neglected the issue. Since 1991, three states have held referenda on the question. California and Washington voted narrowly to retain the ban, Oregon voted even more narrowly to lift it.

They can forget their votes. Judge Stephen Reinhardt and the 9th Circuit Court in San Francisco have decided the issue for them. Congratulating his own steely self-discipline, Reinhardt writes: "We must strive to resist the natural judicial impulse to limit our vision to that which can plainly be observed on the face of the [Constitution]." And resist he does, heroically. In a manifesto longer than the Unabomber's, Reinhardt embraces a "dynamism of constitutional interpretation" and proclaims a

constitutional "right to die" lodged, lo, undiscovered all these years right under our noses in the "liberty interest" of the Due Process Clause of the 14th Amendment.

Until this case was brought, no federal court in American history had ever read the Fourteenth Amendment's "liberty interest" as prohibiting the state from outlawing one person's helping kill another at the latter's request. How did the 9th Circuit?

It drew courage and precedent from the mother of judicial willfulness, the Supreme Court's abortion decisions. The latest such decision, (ital) Planned Parenthood v. Casey (unital), reaffirmed the right to abortion on the grounds that matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."

Well, reasons the 9th Circuit, if aborting a fetus is an intimate and personal choice, how about killing oneself? If the right to abortion is central to personal dignity and autonomy, why not suicide for the terminally ill?

But by the 9th Circuit's logic, why stop there? Why should the state be allowed to interfere with, say, drug-taking? What decision is more private, more "intimate and personal," more an expression of personal autonomy than choosing to alter one's own mood and perceptions through a voluntary act?

And as to the right to assisted suicide, why stop with the terminally ill? Under what principle should the non-terminally ill or even the healthy be denied the autonomy of assisted suicide?

Take the inconsolably bereaved parent who has lost his children in some disaster: not ill. Take the severely disabled young person whose life is a living hell: not terminal. As my distinguished colleague on this panel, Professor Yale Kamisar has pointed out, it is perverse to allow the relief of suicide to the terminally ill whose suffering is about to end shortly anyway, while denying it the non-terminal who face endless decades of unrelieved anguish.

Why deny them the right to assisted suicide? Why deny it to anyone who has had enough of life? What's illness, let alone terminal illness, got to do with it? Under the 9th Circuit's Fourteenth Amendment, why should I not be allowed to open a chain of boutique death chambers -- "Krauthammer's Thanatology Centers" -- ready to assist anyone who walks in the door with this most "intimate and personal" expression of personal autonomy?

III.

The Second Circuit also overturns the law against physician-assisted suicide but on different grounds. It finds its constitutional mandate not in the liberty interest but in the Equal Protection Clause of the 14th Amendment. Judge Miner and the Second Circuit panel argue thus: In the Cruzan case the Supreme Court appears to establish the right of the terminally ill to refuse life-supporting medical treatment. It is therefore unconstitutionally discriminatory to deny terminally ill persons not on life support the equal right to kill themselves by medically active means. If the doctor can pull your plug, he must be permitted to prescribe hemlock.

"Physicians do not fulfill the role of 'killer' by prescribing drugs to hasten death any more than they do by

disconnecting life support systems," writes Judge Miner. This is pernicious nonsense. There is a great difference between, say, not resuscitating a stopped heart -- allowing nature to take its course -- and actively killing someone. In the first case, the person is dead. In the second, he only wishes to be dead. And in the case of life sustained by artificial hydration or ventilation, pulling the plug simply prevents a prolongation of the dying process. Prescribing hemlock initiates it.

The distinction is not just practical. It is psychological. Killing is hard to do. The whole purpose of this case is to make it easier. How? By giving doctors who actively assist suicide the blessing of the law and society.

The prize for judicial presumption, however, goes to Judge Guido Calabresi of the 2nd Circuit in New York for his opinion concurring that current laws banning assisted suicide must be thrown out but for a different -- and revealing -- rationale: They must go because they are obsolete. They were originally enacted at a time when suicide was either a crime or considered a "grave public wrong." Now that suicide is considered neither, he says, the assisted suicide laws make no sense. Calabresi grants that the Constitution and its history do not clearly render these statutes invalid. But that deters him not a bit. He would throw them out anyway until the New York Legislature comes up with new assisted-suicide laws sporting more modern rationales.

But judges rule on the constitutionality of laws, not their currency. Are democratically enacted laws to be stricken until a new moral exegesis can be cooked up to satisfy a judge's personal ethics?

Calabresi presumes that the people of New York retain their prohibition against physician-assisted suicide out of absent-

mindedness. Yet he himself notes that in 1994 a task force of doctors, bioethicists and religious leaders organized at the request of Governor Cuomo concluded --unanimously -- that the "laws prohibiting assisted suicide and euthanasia should not be changed." Yet Calabresi carries on as if no one other than he has bent his mind to the problem.

IV.

Calabresi is a Clinton appointee. Judge Roger Miner, who wrote the 2nd Circuit's majority opinion, was appointed by Reagan. The 9th Circuit majority (1 Kennedy, 5 Carter, 2 Reagan appointees) is similarly ecumenical. Which proves that judicial imperialism is a bipartisan occupational disease.

The Supreme Court would do a great service to the democratic character of this country by reviewing these opinions, overturning them, and remonstrating against the breathtaking arrogance of these imperial judges. It might begin by quoting from the dissent of the 9th Circuit's Andrew Kleinfeld: "That a question is important does not imply that it is constitutional. The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary."

I have no great expectation that over the long run the people and their legislatures would firmly hold the line against physician-assisted suicide. But I would rather see the ban overturned by popular will after vigorous debate than by judicial fiat. If the consequences of permitting assisted suicide turn out to be as baleful as I predict, a democratic decision can always be reversed.

But with constitutional rights there is no further appeal. The debate ends. And as with abortion, all that is left is bitterness, angry demonstrations, and a deep sense of disenfranchisement. Having done that once, are we going to do it again?

Thank you.

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Charles Krauthammer

Deciding On Life Or Death

In the most morally laden judicial decision since *Roe v. Wade*, two U.S. appeals courts (for the 2nd and 9th circuits) have, within the last five weeks struck down as unconstitutional laws banning physician-assisted suicide. Two issues are at stake here: (1) Should physician-assisted suicide be permitted? And (2) should judges be deciding the issue? The first is a difficult question. The second is not.

In this column and elsewhere, I have argued that permitting doctors to kill their patients is a bad idea, however compassionate the motives, principally because the erosion of the taboo against physician-assisted suicide will inevitably lead to abuses. But whatever my private view and whatever the private view of the robed eminences of the 2nd and 9th circuits, is this not an issue that a democratic people ought to decide themselves?

Have these judges learned nothing from *Roe v. Wade*? The United States is the only country in the Western world that has legalized abortion not by popular vote or legislative action but by judicial fiat. The result has been 25 years of social and political turmoil.

Having disenfranchised a democratic people on one of the fundamental moral issues of our time, the courts are now bent on doing it again. Not a single country in the world (save Holland) permits doctors to help patients kill themselves. Now judges have decreed that America will be such a country, indeed that the Constitution demands that America be such a country.

It is not as if the people have neglected the issue. Since 1991, three states have held referenda on the question. California and Washington voted narrowly to retain the ban. Oregon voted even more narrowly to lift it.

Well, they can forget their votes. Judge Stephen Reinhardt and the 9th Circuit

The imperial judiciary strikes again.

Court in San Francisco have decided the issue for them. Congratulating his own steady self-discipline, Reinhardt writes: "We must strive to resist the natural judicial impulse to limit our vision to that which can plainly be observed on the face of the document before us," meaning the Constitution. And resist he does, heroically. In a manifesto longer than the *Unabomber's*, Reinhardt embraces a "dynamism of constitutional interpretation" and proclaims a constitutional "right to die" lodged, lo, undiscovered all these years right under our noses in the "liberty interest" of the Due Process Clause of the 14th Amendment.

(Question: If the liberty interest mandates permitting assisted suicide, how can one justify the current drug laws? If the state may not impinge on your liberty to make yourself dead, how can it impinge your liberty to make yourself high?)

The prize for judicial presumption, however, goes to Judge Guido Calabresi of the 2nd Circuit in New York for his opinion concurring that current laws banning assisted suicide must be thrown out but for a different—and revealing—rationale: They must go because they are obsolete. They were originally enacted at a time when suicide was either a crime or considered a "grave public wrong." Now that suicide is considered neither, he says, the assisted suicide laws make no sense. Calabresi grants that the Constitution and its history do not clearly render these statutes invalid. But that deters him not a bit. He would throw them out anyway until the New York legislature comes up with new assisted-suicide laws sporting more modest rationales.

Are democratically enacted laws to be stricken until a new moral exegesis can be cooked up to satisfy a judge's personal ethics? Judges rule on the constitutionality of laws, not their currency.

Calabresi presumes that the people of New York retain their prohibition against physician-assisted suicide out of absent-mindedness. Yet he himself notes that in 1994 a task force of doctors, bioethicists and religious leaders organized at the request of Gov. Mario Cuomo concluded (unanimously, mind you) that the laws against physician-assisted suicide should be retained. Yet Calabresi carries on as if no one other than he has bent his mind to the problem.

Calabresi is a Clinton appointee. Judge Roger Miner, who wrote the 2nd Circuit's majority opinion, was appointed by Reagan. The 9th Circuit majority (1 Kennedy, 5 Carter, 2 Reagan appointees) is similarly ecumenical. Which proves that judicial imperialism is a bipartisan occupational disease.

Is it too much to hope that the Supreme Court will put a stop to it? It would do a great service to the democratic character of this country by reviewing these opinions, overturning them and remonstrating against the breathtaking arrogance of these imperial judges. It might begin by quoting from the dissent of the 9th Circuit's Andrew Kleinfield: "That a question is important does not imply that it is constitutional. The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary."

Mr. CANADY. Ms. Lee.

**STATEMENT OF BARBARA COOMBS LEE, CHIEF PETITIONER,
OREGON'S DEATH WITH DIGNITY ACT**

Ms. LEE. Mr. Chairman, and members of the committee, thank you very much for inviting me to join you this afternoon.

My name is Barbara Coombs Lee. By training I am a nurse, and a physician assistant and an attorney at law. I appear before you today in my role as the chief petitioner of Oregon's Death with Dignity Act, which was passed by a citizens' initiative in November 1994.

The act creates a safe harbor in Oregon's assisted suicide laws for an attending physician to provide a prescription for lethal medication upon repeated voluntary and informed requests from a competent adult terminally ill Oregon resident. The patient may then obtain the means for a humane and dignified death at the time of his or her own choosing.

The act imposes numerous safeguards, such as repeated written and oral requests, second medical opinions, waiting periods, examination of alternatives, such as comfort care, hospice and pain control. It also provides documentation by the attending physician and oversight by the Oregon State Health Division.

Upon constitutional challenge, the act was found by a Federal district court to fail the equal protection rational basis test, and the State is currently appealing that ruling in the ninth circuit.

How did the movement for this act begin? I think that is a germane question. The movement for Oregon's Death with Dignity Act began with Oregon families that had struggled through prolonged and painful deaths and resolved to change the law. Most specifically, it began with the experience of a woman named Sarah Sinnard, who struggled with a terminal heart disease for a number of years. She and her husband Elvin visited medical centers all over the country searching for some relief from the continuous discomfort and debilitation that she suffered. Finally she reached the point in the course of her disease where any effort, including the effort of talking with her children or reading a book, was sufficient to bring on excruciating pain. She was bedridden.

When she reached that decision that the quality of her life was such that she preferred death to it, she talked with her family, she talked with her minister, and in consultation with them she stockpiled medication, and she read about how to use a plastic bag.

Strangely, and this is a story that we hear again and again, once Sarah had obtained the means of her release, she felt empowered, and her spirits brightened. Over and over again we hear the description of people who finally find the means for the relief of their suffering as though they had been locked in a room that had a door, and finally they found the key. With that key, she obtained the courage and the grace to live on in spite of her disability for a good period of time.

Finally, however, the day came when she decided that her suffering was too great to bear. She carefully constructed an alibi for her husband Elvin and instructed him to go where he would be seen and return to her only after a certain stated number of hours. He did as he was told, and when he returned, indeed he found that

she had taken her life and she was at peace. His grief was greatly intensified, and it is to this day, by his inability to be with his wife at the end.

In spite of Sarah's precautions, Elvin was still subjected to a criminal investigation. The police were called. The house was searched. Articles were confiscated, including the letters that Sarah had written of goodbye to Elvin and her children. Elvin vowed "This isn't right," and he began an organization called Oregon Right to Die that met in his basement.

From that effort came eventually the Oregon Death with Dignity Act, which is now codified in ORS.

The problem which the Sinnard family experienced is that, though medical science has conquered the gentle and peaceful deaths, it has left the humiliating and agonizing to run their relentless downhill course. Faced with this dilemma, the problem that the law presents is that families, loving families, are turned into criminals. Loved ones are separated at the end when it is most important for them to be close. People are driven out of the community that supports them and into isolation, and others are forced to endure a slow and agonizing death that contradicts the very meaning and the sanctity of their lives.

I want to stress that in Oregon the Death with Dignity Act had very broad support. The State Democratic Party, the Republican Dorchester Conference, the National Organization of Women all supported the act as a compassionate response to this desperate situation. I would say, however, that our most vocal support, and certainly our largest contributions, came from people who described themselves as very politically conservative.

These people resent a government that interferes with an intensely private and personal decision and restricts their individual liberty. Many of these, who would otherwise oppose a woman's abortion option on the grounds that there is another life to consider, see no such moral issue in assisted death for terminally ill adults.

During our campaign we argued that physicians already assist their patients, and we were merely codifying and adding safeguards to the status quo. And, in fact, subsequent to the passage of the Death with Dignity Act, surveys in Washington and Oregon and other places have revealed that that is so. The most recent survey that came out in Washington actually revealed that the rate of requests, although covert and surreptitious in Washington, is approximately the same as it is in the Netherlands, and the rate at which physicians respond positively to those requests is also the same. The only difference, of course, is that under the Oregon Death with Dignity Act, there would be guidelines and safeguards and consultation, and without it, these actions are covert, surreptitious, hidden, and out of our reach.

Incredibly some would contend that covert illegal assistance is preferable to decriminalization. As a citizen and an attorney, I believe in an ordered society, and I could not accept a stated policy to wink at the law.

When we know that certain rare and desperate cases call for a compassionate response in the form of assisted death, it seems to me that our democratic heritage demands that the law be consist-

ent with that knowledge. This is uniquely American, but it is how we govern with integrity and retain the consent of the governed. I believe that people like Sarah choose a hastened death because they believe that the circumstances of their death are very important to the meaning and the story and the sanctity of their lives.

They agree with Ronald Dworkin, the philosopher and legal scholar, who said making someone die in a way that others approve, but he believes a horrifying contradiction of this life, is a devastating and odious form of tyranny.

Thank you.

[The prepared statement of Ms. Lee follows:]

PREPARED STATEMENT OF BARBARA COOMBS LEE, CHIEF PETITIONER, OREGON'S
DEATH WITH DIGNITY ACT

Chairman Hyde and members of the Committee, good afternoon. My name is Barbara Coombs Lee. By training I am a nurse, physician assistant, and attorney at law. I appear today in my role as a Chief Petitioner of Oregon's Death with Dignity Act, which was passed by citizen's initiative in November 1994. The Act creates a safe harbor in Oregon's assisted suicide laws for an attending physician to provide a prescription for lethal medication, upon repeated voluntary and informed requests from a competent, adult, terminally ill patient. The patient may then obtain the means for a humane and dignified death at the time of his or her own choosing. The Act imposes numerous safeguards, such as repeated written and oral requests, second medical opinions, waiting periods, and consultation regarding comfort care, hospice and pain control. It also provides for documentation by the attending physician and oversight by the State Health Division. Upon constitutional challenge, the Act was found by a Federal District Court judge to fail the equal protection rational basis test, and the State is currently appealing that ruling at the Ninth Circuit.

The movement for Oregon's Death with Dignity Act began with Oregon families that had struggled through prolonged and painful deaths and resolved to change the law. Elvin Sinnard's wife Sarah suffered with a terminal heart condition that brought excruciating pain with any activity, including reading and talking. She reached her decision in consultation with her family and minister, stockpiled medication and learned how to apply a plastic bag. Heartened by her empowerment, she continued to live for a number of months, but gradually

her suffering became too great to bear. When the day of her decision arrived, she carefully constructed an alibi for her husband and instructed him to go where he would be seen, not to return for a stated number of hours. When he returned she indeed was "at peace" but his grief was intensified at his inability to be with her when she died. In spite of Sarah's precautions, Elvin was still subjected to a criminal investigation. The house was searched and articles confiscated, including Sarah's farewell letters to her family. Elvin vowed "This isn't right," and formed an organization called Oregon Right to Die, which met in his basement.

Patty Rosen's daughter Jody was dying of bone cancer. All the narcotics doctors could provide didn't dull her pain and Jody pleaded with her mother, a nurse, to help her die. The day Patty finally agreed was a happy one for Jody, but complying with her request was not easy because of the drug tolerance that had developed over the previous weeks. Patty eventually succeeded, and lay next to her daughter as she died in her bed.

The problem is that medical science has conquered the gentle and peaceful deaths and left the humiliating and agonizing to run their relentless downhill course. The suffering of these individuals is not trivial and it is not addressed by anything medical science has to offer. Faced with this dilemma, the problem for many is that the law turns loving families into criminals. It separates loved ones at the end, when it is most important to be close. It encourages patients to choose violent and premature deaths while they still have the strength to act. And it forces some to suffer through a slow and agonizing death that contradicts the very meaning and fabric of their lives.

In Oregon the Death with Dignity Act received wide support across genders, ages, and political philosophies. The state Democratic party, ACLU and local National Organization of Women supported the Act as a compassionate response to the dilemma many find themselves in at the end of their lives. But our most vocal support and largest contributions came from people who describe themselves as politically very conservative. They resent a government that interferes in an intensely personal, private decision, and restricts their individual liberty.

Many who would oppose a woman's abortion option on the grounds that there is another life to be considered, see no such moral issue in assisted death for terminally ill adults.

During our campaign we argued that physicians already assist their patients with death in hidden and unstated ways. The initiative would merely bring covert, surreptitious activity into the open and add safeguards. Recent scientific evidence confirms this belief. In February the New England Journal of Medicine published a survey of Oregon physicians taken in early 1995, in which 21% said they had been asked for a prescription for a lethal dose of medication within the preceding year. Seven percent (7%) stated they had written such a prescription prior to passage of the Act, and most of these stated their patients had taken the medication. A survey of Washington State physicians published in the Journal of the American Medical Association last month revealed that 26% of physicians have been asked at least once for a lethal prescription or euthanasia. 147 physicians provided 207 case descriptions of patients who made requests. The physician provided lethal prescriptions to 38 (24%) of those requesting them and 21 patients (55%) took the medication and died. 15 patients (39%) did not use their prescriptions.

Physicians who respond to such requests do so without guidelines, without consultation with their peers, and without referral for second opinion. Improvement in these professional practices is one of the chief salutary effects of decriminalization. With open discussion of symptoms and options comes improvement in care. Since passage of the Death with Dignity Act palliative care has received greatly increased attention in Oregon's medical community and referrals to hospice have increased 20%. Dying individuals and their families are relieved of their burden of secrecy, isolation and fear of prosecution.

Incredibly, some would contend that covert, illegal assistance is preferable to decriminalization. As a citizen and attorney I believe in an ordered society and I could not accept a stated policy to wink at the law. When we know that certain rare and desperate cases call for a compassionate response in the form of assisted death our democratic heritage demands that the law be consistent with that knowledge. Perhaps this is uniquely American,

but it how we govern with integrity retain the consent of the governed.

I believe that one reason people like Sarah, or Jody, or Francois Mitterand choose a hastened death, is because they believe the circumstances of their deaths are very important to the meaning, the story, even the sanctity of their lives. There is something about facing death with courage and grace, with senses intact, that serves their most cherished values and spiritual needs. And I believe, quoting philosopher and legal scholar Ronald Dworkin, that "Making someone die in a way others approve, but he believes a horrifying contradiction of this life, is a devastating, odious form of tyranny."

THE OREGON DEATH WITH DIGNITY ACT

SECTION I GENERAL PROVISIONS

§ 1.01 DEFINITIONS

The following words and phrases, whenever used in this Act, shall have the following meanings:

- (1) "Adult" means an individual who is 18 years of age or older.
- (2) "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- (3) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- (4) "Counseling" means a consultation between a state licensed psychiatrist or psychologist and a patient for the purpose of determining whether the patient is suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.
- (5) "Health care provider" means a person licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care in the ordinary course of business or practice of a profession, and includes a health care facility.
- (6) "Incapable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available. Capable means not incapable.
- (7) "Informed decision" means a decision by a qualified patient, to request and obtain a prescription to end his or her life in a humane and dignified manner, that is based on an appreciation of the relevant facts and after being fully informed by the attending physician of:
 - (a) his or her medical diagnosis;
 - (b) his or her prognosis;
 - (c) the potential risks associated with taking the medication to be prescribed;
 - (d) the probable result of taking the medication to be prescribed;
 - (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
- (8) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
- (9) "Patient" means a person who is under the care of a physician.
- (10) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.
- (11) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of this Act in order to obtain a prescription for medication to end his or her life in a humane and dignified manner.
- (12) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months.

SECTION 2 WRITTEN REQUEST FOR MEDICATION TO END ONE'S LIFE IN A HUMANE AND DIGNIFIED MANNER

§ 2.01 WHO MAY INITIATE A WRITTEN REQUEST FOR MEDICATION

An adult who is capable, is a resident of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with this Act.

§ 2.02 FORM OF THE WRITTEN REQUEST

- (1) A valid request for medication under this Act shall be in substantially the form described in Section 6 of this Act, signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable, acting voluntarily, and is not being coerced to sign the request.
- (2) One of the witnesses shall be a person who is not:
 - (a) A relative of the patient by blood, marriage or adoption;
 - (b) A person who at the time the request is signed would be entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law; or
 - (c) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
- (3) The patient's attending physician at the time the request is signed shall not be a witness.
- (4) If the patient is a patient in a long term care facility at the time the written request is made, one of the witnesses shall be an individual designated by the facility and having the qualifications specified by the Department of Human Resources by rule.

SECTION 3 SAFEGUARDS

§ 3.01 ATTENDING PHYSICIAN RESPONSIBILITIES

The attending physician shall:

- (1) Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily;
- (2) Inform the patient of:
 - (a) his or her medical diagnosis;
 - (b) his or her prognosis;
 - (c) the potential risks associated with taking the medication to be prescribed;
 - (d) the probable result of taking the medication to be prescribed;
 - (e) the feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
- (3) Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily;
- (4) Refer the patient for counseling if appropriate pursuant to Section 3.03;
- (5) Request that the patient notify next of kin;

(6) Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the 15 day waiting period pursuant to Section 3.06.

(7) Verify, immediately prior to writing the prescription for medication under this Act, that the patient is making an informed decision:

(8) Fulfill the medical record documentation requirements of Section 3.09;

(9) Ensure that all appropriate steps are carried out in accordance with this Act prior to writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner.

§ 3.02 CONSULTING PHYSICIAN CONFIRMATION

Before a patient is qualified under this Act, a consulting physician shall examine the patient and his or her relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.

§ 3.03 COUNSELING REFERRAL

If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder, or depression causing impaired judgment, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder, or depression causing impaired judgment.

§ 3.04 INFORMED DECISION

No person shall receive a prescription for medication to end his or her life in a humane and dignified manner unless he or she has made an informed decision as defined in Section 1.01(7). Immediately prior to writing a prescription for medication under this Act, the attending physician shall verify that the patient is making an informed decision.

§ 3.05 FAMILY NOTIFICATION

The attending physician shall ask the patient to notify next of kin of his or her request for medication pursuant to this Act. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

§ 3.06 WRITTEN AND ORAL REQUESTS

In order to receive a prescription for medication to end his or her life in a humane and dignified manner, a qualified patient shall have made an oral request and a written request, and reiterate the oral request to his or her attending physician no less than fifteen (15) days after making the initial oral request. At the time the qualified patient makes his or her second oral request, the attending physician shall offer the patient an opportunity to rescind the request.

§ 3.07 RIGHT TO RESCIND REQUEST

A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication under this Act may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

§ 3.08 WAITING PERIODS

No less than fifteen (15) days shall elapse between the patient's initial oral request and the writing of a prescription under this Act. No less than 48 hours shall elapse between the patient's written request and the writing of a prescription under this Act.

§ 3.09 MEDICAL RECORD DOCUMENTATION REQUIREMENTS

The following shall be documented or filed in the patient's medical record.

- (1) All oral requests by a patient for medication to end his or her life in a humane and dignified manner;
- (2) All written requests by a patient for medication to end his or her life in a humane and dignified manner;
- (3) The attending physician's diagnosis and prognosis, determination that the patient is capable, acting voluntarily and has made an informed decision;
- (4) The consulting physician's diagnosis and prognosis, and verification that the patient is capable, acting voluntarily and has made an informed decision;
- (5) A report of the outcome and determinations made during counseling, if performed;
- (6) The attending physician's offer to the patient to rescind his or her request at the time of the patient's second oral request pursuant to Section 3.06; and
- (7) A note by the attending physician indicating that all requirements under this Act have been met and indicating the steps taken to carry out the request, including a notation of the medication prescribed.

§ 3.10 RESIDENCY REQUIREMENT

Only requests made by Oregon residents, under this Act, shall be granted.

§ 3.11 REPORTING REQUIREMENTS

- (1) The Health Division shall annually review a sample of records maintained pursuant to this Act.
- (2) The Health Division shall make rules to facilitate the collection of information regarding compliance with this Act. The information collected shall not be a public record and may not be made available for inspection by the public.
- (3) The Health Division shall generate and make available to the public an annual statistical report of information collected under Section 3.11(2) of this Act.

§ 3.12 EFFECT ON CONSTRUCTION OF WILLS, CONTRACTS AND STATUTES

- (1) No provision in a contract, will or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end his or her life in a humane and dignified manner, shall be valid.
- (2) No obligation owing under any currently existing contract shall be conditioned or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner.

§ 3.13 INSURANCE OR ANNUITY POLICIES

The sale, procurement, or issuance of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request, by a person, for medication to end his or her life in a humane and dignified manner. Neither shall a qualified parent's act of ingesting medication to end his or her life in a humane and dignified manner have an effect upon a life, health, or accident insurance or annuity policy.

§ 3.14 CONSTRUCTION OF ACT

Nothing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act shall not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide, under the law.

SECTION 4 IMMUNITIES AND LIABILITIES

§ 4.01 IMMUNITIES

Except as provided in Section 4.02:

(1) No person shall be subject to civil or criminal liability or professional disciplinary action for participating in good faith compliance with this Act. This includes being present when a qualified patient takes the prescribed medication to end his or her life in a humane and dignified manner.

(2) No professional organization or association, or health care provider, may subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or other penalty for participating or refusing to participate in good faith compliance with this Act.

(3) No request by a patient for or provision by an attending physician of medication in good faith compliance with the provisions of this Act shall constitute neglect for any purpose of law or provide the sole basis for the appointment of a guardian or conservator.

(4) No health care provider shall be under any duty, whether by contract, by statute or by any other legal requirement to participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this Act, and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

§ 4.02 LIABILITIES

(1) A person who without authorization of the patient willfully alters or forges a request for medication or conceals or destroys a rescission of that request with the intent or effect of causing the patient's death shall be guilty of a Class A felony.

(2) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life, or to destroy a rescission of such a request, shall be guilty of a Class A felony.

(3) Nothing in this Act limits further liability for civil damages resulting from other negligent conduct or intentional misconduct by any person.

(4) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct which is inconsistent with the provisions of this Act.

SECTION 5 SEVERABILITY

§ 5.01 SEVERABILITY

Any section of this Act being held invalid as to any person or circumstance shall not affect the application of any other section of this Act which can be given full effect without the invalid section or application.

SECTION 6 FORM OF THE REQUEST

§ 6.01 FORM OF THE REQUEST

A request for a medication as authorized by this act shall be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, _____, am an adult of sound mind.

I am suffering from _____, which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, the expected result, and the feasible alternatives, including comfort care, hospice care and pain control.

I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

I understand that I have the right to rescind this request at any time.

I understand the full import of this request and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____

Dated: _____

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed this request in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Is not a patient for whom either of us is attending physician.

_____ Witness 1/Date

_____ Witness 2/Date

NOTE. One witness shall not be a relative (by blood, marriage or adoption) of the person signing this request, shall not be entitled to any portion of the person's estate upon death and shall not own, operate or be employed at a health care facility where the person is a patient or resident. If the patient is an inpatient at a health care facility, one of the witnesses shall be an individual designated by the facility.

Mr. CANADY. Professor Kamisar.

STATEMENT OF YALE KAMISAR, CLARENCE DARROW DISTINGUISHED UNIVERSITY PROFESSOR, UNIVERSITY OF MICHIGAN

Mr. KAMISAR. Thank you for inviting me. I don't know who planned this, but everything I am going to say will probably greatly upset the previous speaker, but I shall do the best I can.

First, a preliminary remark, which I hope you do not take out of my 5 minutes. In response to Congressman Frank, as to whether you are legally entitled to commit suicide or whether you have a right to commit suicide, I would say the answer is no. And now I am borrowing from something Prof. Leon Kass once said. He is on the next panel. You have the capacity to do a lot of things. You have the capacity to be a bad husband. You have the capacity to be a bad parent. But I wouldn't say you have the right to be a bad parent or the right to be a bad husband.

Now, why isn't suicide or attempted suicide a crime? The feeling was it doesn't make any sense to punish someone who commits suicide. He is already dead. How are we going to punish him? And you only will punish his relatives and friends and so forth. It doesn't make any sense to punish someone who attempts to commit suicide because he needs psychiatric help or medical help of some sort.

The reason we no longer criminalize attempted suicide is not because we approve of it, not because we think people ought to have the right to do it. We just think the criminal law doesn't fit. We still criminalize assisted suicide because we think that the criminal law can influence third parties, even though it cannot influence the suicidal people themselves.

This is all spelled out in the Model Penal Code. The code is not a religious tract. It is considered the greatest criminal law project of the 20th century and the starting place for all criminal law thinking. It was the work of many law professors, and as far as I know, most were not religious. The code reaffirmed the need to prohibit assisted suicide, and this was done in the 1960's.

I have asked myself why is there so much support for assisted suicide, and indeed voluntary euthanasia, and why is there growing support? I can think of four reasons. One is the power of individual cases; very appealing, very dramatic exceptional cases. We heard Ms. Lee talk about that. We heard Dr. Quill talk about that.

A second reason is the notion—and I think many proponents of assisted suicide have been very effective selling this idea—the notion that the only substantial objection to this practice is based on religious grounds. I don't think that is true.

I might say, incidentally, that if, as you said earlier, Mr. Chairman, President Clinton said that he often agrees with the Catholic Church and that is why he is likely to reaffirm his opposition to assisted suicide, that is an unfortunate statement. As far as I am concerned, there are a lot of other reasons to be opposed to assisted suicide other than showing your agreement with the Catholic Church.

All right. A third reason is well, the doctors are doing it anyhow, so let's legalize it. If the doctors are violating the law now, why won't they violate the law later?

And a fourth reason is confusion over language: "Right to die." "Death with dignity." "Aid-in-dying." There is so much confusion that—the one thing that is never mentioned is the word "euthanasia" or the word "suicide."

Now, let me discuss the reasons I have mentioned more fully and start with the first one. I think the media, whether deliberately or not, helps the cause of assisted suicide or euthanasia because reporters think they are doing a great job if they spend 14 or 15 minutes focusing on one family and showing you how this person is suffering in the last days of Lou Gehrig's disease or some other fatal illness, and we all feel horrible. But the reporters never stop and say—the issue is not what we ought to do in this individual case. The issue, rather, is what is good for society? What is the impact of legalizing assisted suicide on society generally?

Now, Ms. Lee said it is a personal and private matter. It is not. We are not isolated individuals. We are all connected to each other. And once you say you want the law to change, and you want to legislate in favor of assisted suicide, it is no longer a private matter. The change in public policy is going to affect other people.

And we have to ask ourselves not just what we ought to do for this individual patient, but what will the impact of changing public policy be on thousands of old people, sick people, vulnerable people who probably feel a little guilty about being alive right now. According to the literature on the subject, old and seriously ill people are already being pressured to move on and get out of the way. At work is a prejudice against old people called "ageism," really stereotypes about old people, and a feeling, for example, that if you are old and you want to commit suicide, why not? That sounds perfectly rational to younger people.

Now, there are studies that show that hospitals that care primarily for minority individuals, do a much poorer job of pain management. If you are poor or a minority and you have the assisted-suicide option, but you don't have adequate medical care, and you can't afford hospice care, this option would be much more attractive to you than it would to other people.

I think that John Arras, a professor of philosophy and bioethics at the University of Virginia, put it very well. He said, whichever way we go, we are confronted with a choice, and whichever way we go, there are going to be victims. If we reaffirm the current prohibition, there will be victims. We know that. We see them on TV all the time. We see them on documentaries and on talk shows. They are easy to identify. But we don't realize that if we change the law, and legalize assisted suicide, and make it a reasonable option, we are going to put more pressure on certain groups of people, and there are going to be other victims. We heard someone speak about that on the first panel.

Now, this business about the only substantial objections to proposals favoring assisted suicide are based on religious doctrine is an old argument. Glanville Williams, who was the leading proponent of euthanasia and assisted suicide in his time made this statement 40 years ago. I wrote my first article on the subject in response to that statement in an attempt to prove that it is not so, that euthanasia and assisted suicide can be condemned on other grounds than religious ones.

And I think the New York State Task Force Report is strong evidence of this. The report spells out many nonreligious concerns that led all 24 members of the task force to recommend unanimously that the total ban against assisted suicide and euthanasia be maintained. The task force said, for example, that legalizing these practices would be profoundly dangerous for many people who are ill and vulnerable and would hit minority groups particularly hard.

Another reason why this movement has such so much support is the argument that doctors are doing it anyhow, so it would be better to bring it out in the open and formulate standards. And we heard that point of view expressed this morning.

Well, there is a dispute about how widespread it is, but if it is truly, the case that present laws are widely ignored by doctors, why should we expect the doctors to comply with the new laws, which would only authorize assisted suicide in very limited circumstances—only allow it for the terminally ill?

There is a good deal of literature about people other than the terminally ill who are just as deserving of assisted suicide. After all, if there is a basic right to assisted suicide, either people have the right to determine the time and manner of their death or they don't. If there is such a right, and I would say there isn't, but if there is, and the courts say there is, how in the world can we limit this basic right to people who are terminally ill and not apply it to people who are paralyzed or people in wheelchairs or people with severe arthritis, et cetera?

And if we say there ought to be assisted suicide for those people who can't do it themselves and need help, what about people who can't do it even with help—who can't swallow the pills a physician gives them? If there is a right to determine the manner and timing of your death, aren't they entitled to have the doctor administer a lethal drug?

We are told in one breath don't worry, only terminally ill people suffering great pain will be permitted to obtain assistance in committing suicide. But in the next breath we are told, and the ninth circuit and second circuit both based their opinions on this premise, that there is no significant difference between the termination of life support and active intervention to bring about death. If that is true, these courts forgot something. The right to terminate life support is virtually unlimited. It is not limited to the terminally ill or the people with incurable diseases. Anybody who is competent can terminate life support.

So if you are telling us that it is a denial of equal protection to treat people off life support systems differently from those who are on life support, how in the world can you stop someone from saying, I am not terminally ill, but if I were on life support, I could end my life, so I want to end it even though I'm not terminally ill and I am not on life support. Otherwise this person would say I am being denied equal protection.

It seems to me that there is no way legally or psychologically that we are going to stop with the terminally ill. My friend Professor Baron, who comes up after me, is going to say if we go too far down the slope, we can always go back up. I have news for you.

You don't go back up the slope once you go down. It is easier not to go down further than to try to go back up.

The fourth point is about the "right to die" and other foggy labels. There is so much confusion about this. I am in Michigan, and I read the Detroit newspapers, and every week there are 10 letters in support of Jack Kevorkian for the wrong reasons. People say, I am all for Jack Kevorkian. My mother died on a respirator or a feeding tube, and I don't want to die on machines. I have news for them. That battle is over. You don't have to die on machines if you don't want to.

The right to terminate life support has been firmly established. But I think our thinking is so heavily colored by the two great cases, the *Karen Ann Quinlan* case and the *Nancy Cruzan* case, that people still think in terms of let's help people who are in a vegetative state. They don't understand how the law has developed and the proponents of assisted suicide don't make it easy to understand people talk about "death with dignity," which is a term for living wills, and they talk about the "right to die," which is a very confusing term. There are six different kinds of "rights to die."

You do have a right to terminate life support—whether you are in a vegetative state, or not, or seriously ill, or not, but until the ninth circuit and second circuit cases were handed down not a single American appellate court, Federal or State, had ever said there was a right to assisted suicide. Unless you believe—and I don't deny that some people do—unless you believe that the ultimate goal and objective should be that every competent person should have the right to end his or her life for whatever reason he or she thinks is a good reason I don't think many people believe that, but maybe 50 years from now they will, we have to draw a line somewhere. And no line is logical, no line is neat.

Certainly limiting it to the terminally ill is not logical. David Rivlin had 20 years to live. He was paralyzed from the neck down, but he was not terminally ill. Elizabeth Bouvia had 20 years to live too. She was not terminally ill, but she was paralyzed.

It doesn't make sense to limit the right to the terminally ill. Nor can you. You can't limit it to the terminally ill, you can't limit it to assisted suicide, because there will be very compelling cases for active euthanasia.

We have to draw a line somewhere. I say let's draw a line where our culture has drawn the line up to now. Let's draw the line where history and medical tradition has drawn the line—between the termination of life support and active intervention to bring about death.

[The prepared statement of Mr. Kamisar follows:]

PREPARED STATEMENT OF YALE KAMISAR, CLARENCE DARROW DISTINGUISHED
UNIVERSITY PROFESSOR, UNIVERSITY OF MICHIGAN

Against Assisted Suicide — Even a Very Limited Form

YALE KAMISAR*

Professor Robert Sedler is a leading constitutional law professor and a well-known civil liberties lawyer. I think he is right about many things. To cite but one example, I think he was right when he led the ACLU's successful legal attack on certain University of Michigan restrictions on "hate speech."¹ But I cannot agree with him about physician-assisted suicide, no matter how narrowly he frames the issue.²

WHAT IS THE QUESTION?

Professor Sedler did not earn all the civil liberties victories he has won without being a very effective advocate. And as a good advocate he is well aware that, as Justice Frankfurter once said, "[o]n the question you ask depends the answer you get."³ So to get the answer he desires, Sedler frames the issue very narrowly. He speaks only of a "right" or "liberty" to assisted suicide for "*terminally ill* patients" and only for such patients who are "in the *end stages* of their terminal illness."⁴ But is there any principled way to so limit such a right or liberty?

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1. See Judge Avern Cohn's opinion in *Doe v. University of Michigan*, 721 F. Supp. 852 (E.D. Mich. 1989). But see generally CATHARINE A. MACKINNON, *ONLY WORDS* (1993). "Hate speech" is a popular name for expression that stigmatizes or victimizes an individual on the basis of race, ethnicity, religion, sexual orientation, or other listed characteristics.

2. See Robert A. Sedler, *Are Absolute Bans on Assisted Suicide Constitutional? I Say No*, 72 U. DET. MERCY L. REV. 725 (1995) (in this issue, preceding this article).

3. See HENRY J. FRIENDLY, *Mr. Justice Frankfurter*, in *BENCHMARKS* 318-19 (1967).

4. Sedler, *supra* note 2, at 725 (emphasis added). Professor Sedler also tells us that the Michigan criminal law prohibiting assisted suicide (a state law that has since expired) was "specifically directed against the terminally ill." *Id.* I think this statement is misleading in two respects.

First of all, the Michigan law was not specifically directed at people who commit suicide without assistance, but at those who purposely *aid another* to commit suicide. The law did not prohibit either suicide or attempted suicide, see MICH. COMP. LAWS. ANN. § 752.1027 (West Supp. 1993), nor, for that matter, does any American criminal law.

Professor Sedler does not want us to think about the impact on our society of establishing a right or liberty to physician-assisted suicide, however limited (at first). He does not want us to think about other situations where the case for assisted suicide may be equally strong. He only wants us to focus on a very narrowly circumscribed set of circumstances.

Why is that? I think it is because, as Sedler and his colleagues are well aware, a severely circumscribed right to assisted suicide would cause less alarm and command more support than a less restricted one. Most of us balk at the notion of actively intervening to promote or to bring about the death of innocent persons. But if only the terminally ill and, still more narrowly, only those in the final stage of their terminal illness, are afforded a right to assisted suicide, we can still manage to reassure ourselves that such a development constitutes only a very, very slight deviation from our social norms.

Thus, a proposal for a rigorously circumscribed right to assisted suicide or a claim that the Constitution protects a very limited right to assisted suicide is quite inviting; one might even say, seductive. And, if I may quote Justice Frankfurter again, "[t]he function of an advocate is . . . to . . . seduce"⁵

On second glance, Professor Sedler's proposal may be even more narrowly circumscribed than I have indicated. Although early in his

However, the fact that there is no form of punishment acceptable for a "completed suicide" and that a criminal prohibition is "singularly inefficacious" to deter attempted suicide:

Does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of, the suicide victim.

MODEL PENAL CODE § 210.5 Commentary at 94,100 (Official Draft and Revised Commentaries 1980).

In the second place, the Michigan law was not specifically aimed at the *terminally ill* or those who help the terminally ill commit suicide. The law made it a felony for anyone who knew that another person intended to commit suicide (whether that other person was terminally ill or not, physically disabled or not, seriously ill or not) to "provide the physical means" by which that other person committed suicide or to "participate in a physical act" by which the other person did so. See George Annas, *Physician-Assisted Suicide — Michigan's Temporary Solution*, 328 NEW ENG. J. MED. 1573, 1574 (1993).

If the Michigan anti-assisted suicide law was specifically directed at any group or any person, it was aimed at Dr. Jack Kevorkian. And it is well known that at least some of Kevorkian's patients (including his very first one) were *not* terminally ill, as that condition is usually defined. See *infra* notes 22-23 and accompanying text.

5. FELIX FRANKFURTER, FELIX FRANKFURTER ON THE SUPREME COURT 509, 511 (Philip B. Kurland ed. 1970).

talk, he speaks only of the end stages of terminal illness,⁶ later on he seems to require another factor—unbearable pain and suffering. On two occasions, for example, he asks whether the government can force terminally ill persons to suffer until they have breathed their “last agonizing breath.”⁷

I do not deny that one may imagine situations, or recall actual ones, that constitute very dramatic, very compelling, cases for assisted suicide (or active voluntary euthanasia for that matter). But I do not believe that a narrow exception to the current prohibition against assisted suicide would or could remain a narrow exception for very long. As I shall try to show, I do not believe there is any principled way to limit the right to physician-assisted suicide to the terminally ill even to those suffering unbearable or great physical pain.

More generally, I share the conclusion of the New York State Task Force on the Life and the Law that, although acts of assisted suicide or active euthanasia may be “morally acceptable in exceptional cases,”⁸ such cases cannot justify explicit changes in existing legal or moral rules.⁹

As might be expected, the twenty-four members of the New York Task Force had different views about individual acts of assisted suicide and euthanasia.¹⁰ Some members believed that “assisted suicide is ethically acceptable in certain cases.”¹¹ Nevertheless, these members joined their colleagues in unanimously recommending that existing law should not be changed to permit assisted suicide (or active voluntary euthanasia).¹² Every member of the Task Force concluded that “the potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved.”¹³

And, reported the Task Force, the dangers of such a change would be the greatest for the elderly, the poor, and the socially disadvantaged:

6. See Sedler, *supra* note 2, at 725, 727, 728.

7. See *id.* at 727, 728.

8. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 102 (1994) [hereinafter NEW YORK STATE TASK FORCE REPORT].

9. See *id.*

10. The Commission, appointed by Governor Mario Cuomo, was made up of eight medical doctors (two of whom were deans of medical schools), two bioethicists who were not medical doctors, four lawyers, six clergymen (one of whom was also a law professor), the state commissioner of health, the state commissioner on the quality of care for the mentally disabled, and a member of the New York Civil Liberties Union. In addition, three medical doctors and a nurse served as consultants. See *id.* at ii-iii.

11. *Id.* at 120.

12. See *id.*

13. *Id.*

[I]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society—only that they are not exempt from the prejudices manifest in other areas of our collective life.¹⁴

* * *

[Many patients] in large, overburdened facilities serving the urban and rural poor . . . will not have the benefit of skilled pain management and comfort care. Indeed, a recent study found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain. Many patients will also lack access to psychiatric services. Furthermore, for most patients who are terminally or severely ill, routine psychiatric consultation would be inadequate to diagnose reliably whether the patient is suffering from depression.¹⁵

For similar reasons, not long ago (February, 1992), the ABA House of Delegates rejected a resolution by the Beverly Hills Bar Association that would have supported a California ballot initiative to legalize physician "aid-in-dying." (The "aid-in-dying" label covered *both* physician-assisted suicide *and* physician-administered active voluntary euthanasia.)¹⁶ The opposition to the Beverly Hills resolution was led by John Pickering, the Chair of the ABA Commission on Legal Problems of the Elderly. I think a point Mr. Pickering made on that occasion bears repeating:

[The resolution] calls for "voluntary aid in dying . . . without undue influence or duress. . . ." Before there can be such truly voluntary choice to terminate life, there must be universal access to affordable health care. The lack of access to or the financial burden of health care hardly permit voluntary

14. *Id.* at 125 (footnote omitted).

15. *Id.* at 143 (footnotes omitted) (citing C. S. Cleeland et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 320 N. ENG. J. MED. 592-96 (1994)).

16. See generally Alexander Morgan Capron, *Proposition 161: What Is at Stake?*, COMMONWEAL, Sept. 1992 (Special Supp.), at 2. The California proposal to legalize "aid-in-dying" (Proposition 161) failed by a 54 percent to 46 percent margin. See Alexander Morgan Capron, *Even in Defeat, Proposition 161 Sounds a Warning*, HASTINGS CENTER REP., Jan. - Feb. 1993, at 32.

choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts.¹⁷

IF A "RIGHT" OR "LIBERTY" TO PHYSICIAN-ASSISTED SUICIDE WERE ESTABLISHED, WOULD (COULD) IT BE LIMITED TO THE "TERMINALLY ILL"?

As I understand it, the basic argument for assisted suicide is "personal autonomy" or "self-determination" or, as Professor Sedler puts it, paraphrasing the language in *Planned Parenthood v. Casey*,¹⁸ "the right to define one's own concept of existence and to make the most basic decisions about bodily integrity."¹⁹ But if one believes that respect for "self-determination" and "personal autonomy" entitles a person to decide for herself whether, when, and how she wishes to end her life, I do not see any principled way in which this right or liberty can be limited to the "terminally ill," let alone persons in the end stage of a terminal illness.

According to Sedler, "[o]bviously, the terminally ill person will not seek to hasten inevitable death until the end stage of the terminal illness has been reached."²⁰ This is not at all obvious to me. It would not surprise me, for example, if someone who learns she has terminal cancer or is HIV positive would seek assistance in ending her life shortly after she heard the bad news. It would surprise me even less if someone in the early stages of Alzheimer's disease, anticipating and fearing mental deterioration some years down the road, would seek

17. Mr. Pickering's arguments in opposition to the Beverly Hills resolution are set forth in a memorandum of January 17, 1992, which is quoted at length in John H. Pickering, *The Continuing Debate over Active Euthanasia*, BIOETHICS BULLETIN (ABA), Summer 1994, at 1, 2.

Shortly after I gave the talk on which this article is based, a conference participant, Dr. Ralph D. Cushing, who treats people with AIDS at Bon Secours Hospital in Grosse Pointe as well as at Detroit Receiving Hospital, expressed the view that there is a "racist" component to the issue of physician-assisted suicide. See Dave Farrell, *Assisted Suicide A Troubling, Divisive Issue for State Doctors*, DETROIT NEWS, Nov. 20, 1994, at 4C (reporting on the conference). According to Dr. Cushing, inner-city patients, many of them poor African-Americans, would be most likely to seek and to obtain physician-assisted suicide, if it were legal. See *id.* Explained Dr. Cushing: "It seems to me that a person with less options for medical care is more likely to fall into despair. And that is when these kinds of decisions are made—when the patient is depressed and believes there is no hope." *Id.*

See also John D. Arras, *The Right to Die on the Slippery Slope*, 8 SOC. THEORY & PRAC. 285, 304 (1982) (predicting that if active voluntary euthanasia were made legal, most dying patients in the middle and upper classes would probably opt for hospice care, but "the poor, who because of their poverty, lack access to mainstream medical care and the amenities of the hospice," would find euthanasia "much more attractive").

18. 505 U.S. 833, 851 (1992). The language about defining one's own concept of existence is discussed *infra* in the text accompanying notes 139-51.

19. Sedler, *supra* note 2, at 728.

20. *Id.* (emphasis added).

assistance in ending her life *before* the disease progressed any further. This, essentially, describes the plight of Janet Adkins, Dr. Kevorkian's first "suicide patient."²¹

But someone in Janet Adkins' situation would not satisfy Professor Sedler's criteria because she would not be "terminally ill" as that term is usually defined; if Adkins had not availed herself of Kevorkian's services, she "might easily have lived for many more years."²² (Terminal illness is commonly defined as a condition that will produce death "imminently" or "within a short time" or in six months or a year.)²³

If there is some constitutionally protected right or liberty to decide whether, when and how to end one's life—"to determine the timing of [one's] death"²⁴—surely it would or should apply to someone in Adkins' situation. Why should she have to wait until the final phase of Alzheimer's disease? Does personal autonomy apply to matters of life and death, or doesn't it?

It should be noted that Dr. Timothy Quill, a forceful and eloquent proponent of physician-assisted suicide, would not limit that right to the terminally ill. As he explains, he does not want "to arbitrarily exclude persons with incurable, but not imminently terminal, progressive illness."²⁵ But why stop there? Is it any less arbitrary to exclude the quadriplegic? The victim of a paralytic stroke? The mangled survivor of a road accident?

If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide, why exclude those with non-terminal illnesses or disabilities who might have to endure greater pain and suffering *for much longer periods of time* than those who are expected to die in the next few weeks or months? If the terminally ill do have a right to assisted suicide, doesn't someone who must continue to live what *she considers* an intolerable or unac-

21. See JUDITH AHRONHEIM & DORON WEBER, FINAL PASSAGES: POSITIVE CHOICES FOR THE DYING AND THEIR LOVED ONES 14-15, 36, 74 (1992); MICHAEL BETZOLD, APPOINTMENT WITH DOCTOR DEATH 41-46 (1993).

22. AHRONHEIM & WEBER, *supra* note 21, at 74. See also PETER SINGER, RETHINKING LIFE AND DEATH 133 (1995) (Janet Adkins "knew that she might live another ten years or more").

23. See Yale Kamisar, *When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live?"*, 25 GA. L. REV. 1203, 1210-11 (1991); Thomas Marzen, "Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill, 21 HASTINGS CONST. L.Q. 799, 814 (1994). As pointed out in AHRONHEIM & WEBER, *supra* note 21, at 74, "even by the standards of the Hemlock Society, of which [Adkins] was a member, she was not 'terminal'—defined by the organization as having six months or less to live"

24. Sedler, *supra* note 2, at 728. Professor Sedler further states: "[T]he question is whether [a terminally ill] person will have the choice to hasten inevitable death—to determine the timing of death—or whether that person must continue to suffer until she breathes her last agonizing breath." *Id.*

25. TIMOTHY QUILL, DEATH AND DIGNITY 162 (1993) (emphasis added).

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ceptable existence for many years have an equal—or even greater—right to assisted suicide?

If a *competent* person comes to the unhappy but firm conclusion that her existence is unbearable and freely, clearly and repeatedly requests assisted suicide, and there is a constitutional right to some form of assisted suicide, why should she be prevented from obtaining the assistance of another to end her life just because she does not “qualify” under somebody else’s standards? Isn’t *this* an arbitrary limitation of self-determination and personal autonomy? As Daniel Callahan has observed: “How can self-determination have any limits? [Assuming a person is competent and determined to commit suicide with the assistance of another,] [w]hy are not the person’s desires or motives, whatever they may be, sufficient?”²⁶

There is another reason I very much doubt that if a right to assisted suicide were established for the terminally ill, it could and would remain limited to the terminally ill for very long. As I understand the position of Sedler and other proponents of a right to assisted suicide, one should have the same right to enlist the aid of others to commit suicide as one presently has to refuse or to withdraw life-sustaining medical treatment. Professor Sedler puts it quite strongly. He sees no “principled difference, in terms of constitutional doctrine and precedent,” between the alleged right to assisted suicide and the established right to terminate life support.²⁷ (Nor did Barbara Rothstein, Chief Judge of the United States District Court in Seattle, who recently became the first federal judge to strike down, as violative of the Fourteenth Amendment, a state law prohibiting all assisted suicide.)²⁸

But if, as proponents of assisted suicide maintain, there is no significant difference between the right to assisted suicide and the right to reject unwanted life-saving treatment, it is fairly clear that, once established, the right to assisted suicide would not be limited to the terminally ill. For the right of a person to reject life-sustaining medical treatment *has not been so limited*.

One need only recall the *Elizabeth Bouvia* case,²⁹ one of the best known “right to die” cases in this country (probably the third most

26. DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE* 107-08 (1993).

27. Sedler, *supra* note 2, at 729 (emphasis in original).

28. *Compassion in Dying v. Washington*, 850 F. Supp. 1454 (W.D. Wash. 1994). Several months after I gave my talk, Judge Rothstein’s decision was reversed. See *Compassion in Dying*, 49 F.3d 586 (9th Cir. 1995). At one point in his opinion reversing Judge Rothstein, Judge Noonan, who wrote for a 2-1 majority, observed: “At the heart of the district court’s decision appears to be its refusal to distinguish between actions taking life and actions by which life is not supported or ceases to be supported.” *Id.* at 593. As this article went to press, the Ninth Circuit announced that the Chief Judge and ten other members of the Court would rehear the case *en banc*. 62 F.3d 299 (1995).

29. *Bouvia v. Superior Court (Glenchur)*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986).

famous case in its field, behind only the *Quinlan* and *Cruzan* cases).³⁰ At the time of the litigation, Ms. Bouvia, a young woman afflicted with severe cerebral palsy, had a long life expectancy. Nor was she unconscious or mentally impaired. Indeed, the court described her as both "intelligent" and "alert."³¹ Nevertheless, she was granted the relief she sought—the right to remove a nasogastric tube keeping her alive against her wishes.

To be sure, neither the *Bouvia* case nor other cases upholding the right of non-terminally ill persons to reject life-saving treatment³² were decided by the United States Supreme Court. But *Bouvia* and these other cases have been well received by bioethicists and medico-legal commentators. As Professor John Regan pointed out at this symposium, the highest court of New York and courts across the land have come to recognize that patients have "a virtually absolute right to refuse life-sustaining treatment, so long as they are competent in making that choice."³³

In an effort to draw a bright line between the terminally ill and all others who might seek help in committing suicide, Professor Sedler contends that the state "cannot assert any conceivably valid interest"³⁴ in requiring a terminally ill person to wait until death comes naturally because "there can be no valid interest in 'preserving life' when there is no 'life left to preserve,'"³⁵ and "for the terminally ill there is no life left to preserve."³⁶ I must say I do not understand this argument.

A terminally ill person, for example, a cancer patient who, despite our best medical efforts, is likely to die in a number of months, is still a "person" or a "human being." Moreover, a terminally ill patient's mental powers can hardly be greatly impaired if she retains the

30. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

31. See *Bouvia*, 225 Cal. Rptr. at 300, 305.

32. See *Fosmire v. Nicoleau*, 75 N.Y.2d 218 (N.Y. 1990); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989); *Thor v. Superior Court (Andrews)*, 855 P.2d 375 (Cal. 1993). *Fosmire* sustained the right of a patient to refuse blood transfusions following a Cesarean delivery despite the fact the patient was responsible for the care of her infant. *McKay* and *McAfee* involved respirator-dependent quadriplegics who apparently had long life expectancies. *Thor* involved a state prison inmate, rendered quadriplegic as a result of a fall while in prison, who refused to consent to medication or artificial feeding.

33. See remarks of John J. Regan at the University of Detroit Mercy Symposium on Assisted Suicide and Euthanasia, November 18, 1994 (on file with the *University of Detroit Mercy Law Review*). See also 1 ALAN MEISEL, *THE RIGHT TO DIE* 470 (2d ed. 1995) (study of "new generation of right-to-refuse-treatment cases . . . leads to the conclusion that the right of a competent person to refuse medical treatment is virtually absolute").

34. Sedler, *supra* note 2, at 729.

35. Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, 23 HASTINGS CENTER REP., Sept. - Oct. 1993, at 20, 24 (emphasis in original).

36. Sedler, *supra* note 2, at 730.

decision-making capacity necessary to invoke the right to assisted suicide. (For the present, at least, proponents of assisted suicide are not contending that *incompetent* persons should be entitled to enlist the assistance of others in committing suicide.) Thus, if a right to assisted suicide for the terminally ill were established, an individual could only exercise such a right if she were capable of making a voluntary and informed choice. How can it be said that such a person has "no life left to preserve"?

To be sure, a terminally ill person may *feel* or honestly *believe* that what is left of her life is not a "life" worth preserving. But so too may many others suffering from serious illnesses or disabilities, who are not terminally ill.

A person paralyzed from the neck down may forcefully argue that, although she has a long life expectancy, she has less "life" to live than a terminally ill person who, though seriously ill, is still better able to function in society in the months she has left. The same argument may be plausibly made by a multiple sclerosis patient who, though *not* terminally ill, is so debilitated by her illness that she cannot move from her nursing home bed or eat or perform bodily functions without the assistance of others. Indeed, very recently, Professor Sedler discussed the constitutional status of the multiple sclerosis patient described above (I simply reproduced his description) and concluded that she, as well as a terminally ill person, had a constitutional right to suicide.³⁷

At this symposium Professor Sedler has painted a bright line between the terminally ill and all others who seek assistance in committing suicide. But less than a year earlier he grouped together the terminally ill *and* those who, though they "may live for some additional years,"³⁸ are "so physically debilitated that for them life has become unendurable,"³⁹ maintaining that those falling into *either* category should have a constitutional right to obtain the assistance they need to end their lives by suicide.⁴⁰

Is it any wonder that I do not believe that a right to assisted suicide for the terminally ill will be confined to the terminally ill for very long?

37. See Robert A. Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View from Without and Within*, 21 HASTINGS CONST. L.Q. 777, 791-93 (1994).

38. *Id.* at 792.

39. *Id.* at 793, 795. See also *id.* at 797.

40. See *id.* at 795: "[W]here it matters, bans on assisted suicide should be held to be unconstitutional. These bans matter for people who are terminally ill and for people who are so physically debilitated that for them life has become unendurable."

CAN (SHOULD) THE RIGHT TO ASSISTED SUICIDE BE
LIMITED TO THOSE UNDERGOING GREAT "PAIN
AND SUFFERING"?

Although Professor Sedler's position on the issue is not perfectly clear, a restriction frequently placed on the right to assisted suicide is that the person asserting this right must be experiencing great "pain and suffering" (two classifications commonly lumped together, but hardly identical).

If this restriction means great physical pain, very, very few people *should* qualify for assisted suicide. Although pain is notoriously under-treated in this country,⁴¹ "according to experts in the field of pain control, almost all terminally ill patients can experience adequate relief with currently available treatments."⁴² Thus, the Memorial Sloan-Kettering Cancer Center's Kathleen Foley, a well-known expert on pain control, reports that suicidal ideation and suicide requests "commonly . . . dissolve with adequate control of pain and other symptoms."⁴³

If the "pain and suffering" restriction means "suffering" (including "psychological suffering"), not physical pain, we are no longer talking about a relatively small, easily identifiable group. Physicians can and should relieve physical pain, but "suffering" is a more complex matter: "When euthanasia [or assisted suicide] is requested, the doctor is being asked to act upon someone else's subjective suffering—variable from person to person, externally unverifiable, and always, in principle, reversible"⁴⁴

41. See AHRONHEIM & WEBER, *supra* note 21, at 99-114.

42. *Id.* at 102.

43. Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, J. PAIN & SYMPTOM MGMT. 289, 290 (1991). Adds Dr. Foley, "The high cost of pumps, drugs, and home care supervision on a 24-hr basis makes [pain control] only available to a limited number of patients who have appropriate health care coverage. By rationing pain management on a financial basis, patients are being forced to consider death as their only option." *Id.* at 292.

As Lord Goff of Chieveley recently recalled, when Dame Ciceley Saunders, founder of the modern hospice movement, took the head of the British "Voluntary Euthanasia Society round the hospice and explained her work to him", he wrote to her afterwards that " 'there would be little or no problem of euthanasia if all the terminal disease folk could end their lives in that atmosphere you have done so much to create—but alas that can hardly be for many a long year.' " Robert Goff, *A Matter of Life and Death*, 3 MED. L. REV. 1, 18 (1995), (quoting SHIRLEY DU BOULAY, CICELEY SAUNDERS 180 (rev. ed. 1994)).

44. CALLAHAN, *supra* note 26, at 102. See also Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, — U. RICH. L. REV. (forthcoming 1995):

No evidence could establish that a patient is not suffering the severe and unrelenting suffering he claims, or which the doctor subsequently claims the patient claimed. . . . Repeated requests for PAS [physician-assisted suicide] do not prove suffering so much as they prove determination, and exactly this

If a right to assisted suicide were established, how could this right be denied an otherwise eligible person who *says*, indeed *insists*, that her "externally unverifiable" suffering is intolerable? As a practical matter, would we not defer to the patient's own assessment of her suffering? As a matter of principle, shouldn't we?

So long as a person is competent and her desire to enlist the aid of others in dying by suicide firm and persistent, why should her "right" to end her life in the manner she chooses (if such a right exists) be denied because her suffering does not satisfy someone else's standard?

If and when a right to assisted suicide is established, any requirement that the patient experience "unbearable" or "intolerable" suffering (or "pain and suffering") will probably turn on the patient's own view of her suffering—or drop out entirely.⁴⁵

WILL THE FINE LINE BETWEEN ASSISTED SUICIDE AND ACTIVE VOLUNTARY EUTHANASIA ENDURE FOR VERY LONG?

How does active voluntary euthanasia differ from assisted suicide? Active voluntary euthanasia occurs when someone other than the person who is to die performs the last act—the one that actually brings about death. Assisted suicide takes place when another person provides assistance (for example, provides the physical means to commit suicide), but the person whose life is to be ended performs the last, death-causing act herself. "Recent [court] decisions draw a distinction between active participation in a suicide [murder] and involvement in the events leading up to the suicide, such as providing the means [assisted suicide]."⁴⁶

Because assisted suicide is less widely condemned by the criminal law and the fact that the final act is in the patient's hands is seen as

kind of determination would well serve to make *prima facie* plausible claims that comfort care has failed—and there would be no way, in the face of a patient's insistence that it had failed, to prove it had not.

45. Cf. Albert Jonsen, *To Help the Dying Die — A New Duty for Anesthesiologists?*, 78 ANESTHESIOLOGY 225, 227 (1993):

[F]ear of uncontrolled pain [and, I would add, "unbearable suffering"] is no longer a major feature of the justifying arguments [for "aid-in-dying"]. Autonomy, not pain or its merciful alleviation, is the principal and even sole justifying argument offered by modern proponents.

46. *People v. Kevorkian*, 527 N.W.2d 714, 736 (Mich. 1994), *cert. denied*, 115 S. Ct. 714 (1995). The *Kevorkian* majority discusses, and seems to agree with, two cases from other jurisdictions where the courts found the defendant guilty of murder (which is how American criminal circles currently view active voluntary euthanasia) not assisted suicide: *People v. Cleaves*, 280 Cal. Rptr. 146 (Cal. Ct. App. 1991) (defendant held decedent down to keep him from falling off bed while decedent completed an act of self-strangulation); *States v. Sexson*, 869 P.2d 301 (N.M. Ct. App. 1994) (defendant held rifle in position while wife pulled trigger of rifle that killed her).

offering more protection against potential abuse,⁴⁷ assisted suicide causes less alarm than active euthanasia and generally commands more support. But I think the two practices are much more alike than they are different—both involve the active intervention of another to promote or to bring about death.

As I have spelled out in some detail elsewhere,⁴⁸ one who looks at the media's treatment of the legal and ethical problems raised by the so-called right to die, or even the medico-legal literature on the same subject, quickly discovers that the line between assisted suicide and active voluntary euthanasia is often blurred and sometimes obliterated. Moreover, the emergence of such phrases as "aid-in-dying" and "physician-assisted death," terms which cover *both* assisted suicide and active euthanasia,⁴⁹ have further smudged the distinction between the two practices.

While the distinction is hard to maintain in practice⁵⁰ it is even harder to defend as a matter of principle. If a person who resolves to

47. See Herbert Hendin, *Selling Death and Dignity*, 25 HASTINGS CENTER REP., May - June 1995, at 19.

48. See Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in EUTHANASIA EXAMINED 225, 230-33 (John Keown ed., 1995); Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23 HASTINGS CENTER REP., May - June 1993, at 32.

49. See authorities cited *supra* note 16 and accompanying text; *infra* text accompanying note 55; see also Timothy E. Quill, *The Care of Last Resort*, N.Y. TIMES, July 23, 1994, at 15A (repeated use of the term "physician-assisted death").

50. Consider the following: A competent patient who has resolved to die by suicide and made her wish clear accomplishes her purpose by swallowing a lethal dose of medication which her physician has placed (a) on the night stand next to her bed, (b) in her hand, (c) in her mouth. Has the physician committed murder (which is how active voluntary euthanasia is currently regarded) or has she assisted in a patient's suicide? Compare Lawrence O. Gostin, *Drawing a Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 J.L. MED. & ETHICS 94, 96 (1993) with Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, *supra* note 48, at 230-31.

It may be argued that when a physician puts a lethal dose of medication in a patient's hand he is actively participating in an act that directly causes death. On the other hand, it may be argued that when a physician puts the means of committing suicide in a patient's hand, the lethal process has not yet become irreversible; the patient can still change her mind and put the medication on her night stand or throw it away instead of placing it in her mouth. However it comes out, the line between (a) putting a lethal dose of medication in a patient's hand and (b) putting it on top of her pillow or on her night table seems excruciatingly thin.

I think placing a lethal dose of medication in a person's mouth at her request would strike many people as a clear case of active voluntary euthanasia. But suppose a physician tells her patient: "I am going to place some lethal medication in your mouth, but don't be in a hurry to swallow it. You still have a choice. It's your life. I'm going to leave the room. If you decide that when all is said and done you do not want to die by suicide, that is your right. Simply remove the substance from your mouth or, if you prefer, spit it out." Suppose further that, after the physician leaves the room, the patient swallows the medication. It is not at all clear to me that this is active voluntary euthanasia rather than assisted suicide.

end her life, but is unable to do so without another's help, is entitled under certain circumstances to the assistance of another in bringing about her own death, what about the person who is similarly determined to end her life but *unable* to perform the last, death-causing act herself? Why should she be denied the assistance of another in carrying out the final act; i.e., denied active euthanasia?

If the claim that one has, or ought to have, a right to control the time and manner of one's death is well founded—if one who is terminally ill has, or ought to have, the right to make the choice whether or not to go on living until death comes naturally—how can this right be denied to someone simply because she cannot swallow the barbiturates that will bring about death?

Physician-assisted suicide may be less alarming than physician-administered active euthanasia and may be regarded as a lesser deviation from our social norms, but once we cross the line between the rejection of life-sustaining medical treatment and the active intervention of another to promote or to bring about death, I do not see how we could (or why we would) stop short of active voluntary euthanasia.

Until recently, Dr. Timothy Quill and Dr. Diane Meier would have disagreed with me. In 1992 they announced their support for physician-assisted suicide (under certain conditions), but balked at active voluntary euthanasia.⁵¹ Although Quill and Meier recognized that excluding active voluntary euthanasia from "a continuum of options for comfort care" occurs at "a cost to competent, incurably ill patients who cannot swallow or move, and who therefore cannot be helped to die by assisted suicide,"⁵² they opposed legalizing any form of active euthanasia "because of the risk of abuse it presents."⁵³ Access

51. See Timothy E. Quill, et al., *Sounding Board: Care of the Hopelessly Ill — Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380 (1992); see also Quill, *supra* note 25, at 155-67. As Dr. Quill points out, much of the 1992 article he co-authored is reproduced in chapter eight of his 1993 book. *Id.* at 155.

52. Quill et al., *supra* note 51, at 1381.

53. *Id.* According to Dr. Quill and his co-authors, because in assisted suicide "the final act is solely the patient's," and thus "the risk of subtle coercion from doctors, family members, institutions, or other social forces is greatly reduced," the "balance of power between doctor and patient is more nearly equal in physician-assisted suicide than in euthanasia." *Id.* But see Callahan & White, *supra* note 44:

Notably, arguments of [the kind made by Dr. Quill and his co-authors] do not cite any empirical studies to show there is less coercion and a greater balance of power. There are no such studies. The claim is pure assertion, and not a very plausible one at that. To insinuate the idea of suicide into the mind of someone already grievously suffering can surely be no more difficult than insinuating the idea of euthanasia; indeed, it could be all the more manipulative if the insinuated hint was combined with a tacit flattery of someone's capacity to act on his or her own.

As for the power of doctors, their general prestige as professionals who by training and experience are widely thought better to understand matters of life and death than the rest of us, and their capacity to give or withhold

to medical care in this country, they pointed out "is currently too inequitable, and many doctor-patient relationships too impersonal, for us to tolerate the risks of permitting active voluntary euthanasia."⁵⁴

When I first read these comments by Quill and Meier, my reaction was: Why can't the very same thing be said about not tolerating the risks of permitting *assisted suicide*? Shouldn't we either legalize both assisted and active euthanasia or *continue to prohibit* both?

On reading the comments Quill and Meier made in 1992, it also struck me that their approach to euthanasia was not very different from mine. When it came to assisted suicide, they were what might be called "act utilitarians" and I was what might be called a "rule utilitarian" (one who does not believe that the beneficial consequences of individual acts are decisive when one makes public policy). But when it came to euthanasia, *all of us*, it seemed, were inclined to be "rule utilitarians."

That was 1992. Two years later, Drs. Quill and Meier took a decidedly more "act utilitarian" approach. They no longer defended an absolute prohibition against active euthanasia. Along with four others, they co-authored an article endorsing what they euphemistically called "physician-assisted death," a term not limited to assisted suicide. Under certain circumstances, they now maintained, individuals should be entitled to obtain active voluntary euthanasia as well:

To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so. The method chosen is less important than the careful assessment that precedes assisted death.⁵⁵

Quill and Meier were not the only well-known commentators in the field to shift their position on euthanasia. In 1993 Lawrence Gostin, then the Executive Director of the American Society of Law, Medicine and Ethics (and now a member of the Georgetown Law Center faculty), proposed decriminalizing assisted suicide under certain conditions, but not active euthanasia under any circumstances (evidently because he respected the bright line between active killing

lethal drugs, already establishes the power differential between themselves and their patients.

In any event, the view held by Quill and Meier in 1992 that the "balance of power" between physician and patient was more nearly equal in assisted suicide than in euthanasia did not keep them from crossing the line between assisted suicide and euthanasia two years later. See *infra* note 55 and accompanying text.

54. Quill et al., *supra* note 51, at 1381.

55. Franklin G. Miller et al., *Sounding Board: Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED 119, 120 (1994).

and "letting die.")⁵⁶ A year later, however, Gostin signed the same article Doctors Quill and Meier did, concluding that the legalization of "physician-assisted death" could not be limited to those patients who possessed the capacity to carry out the final act themselves.⁵⁷

The fact that several participants in the debate on death and dying drew a distinct line between assisted suicide and active euthanasia only to ignore that line within the span of a few years is further evidence, I think, that the distinction between physician-assisted suicide and physician-administered active voluntary euthanasia is too thin a line to endure for very long.

LIBERALS, CONSERVATIVES AND "SLIPPERY SLOPE" ARGUMENTS

Professor Sedler wants us, and wants the courts, to focus on a specific and narrow question: Do terminally ill patients have a right to physician-assisted suicide? He does not want us, or the courts, to consider the impact, if any, of an affirmative answer on "our views about death and dying or the sanctity of life."⁵⁸ He assures us that "we need not worry about any 'slippery slope'".⁵⁹

Professor Sedler has made the point before. Indeed, he has gone so far as to say that the kind of "slippery slope" arguments I have made in the course of defending the absolute prohibition against assisted suicide have "no place" in constitutional litigation and cannot be utilized "to avoid" grappling with the specific and narrow question he and his colleagues have framed.⁶⁰

I must disagree. I do not believe a court can *responsibly* resolve the constitutional issue Sedler and others have presented *without* considering the general implications of the asserted right. Surely a judge should not put on blinders and forge straight ahead without thinking about the impact of her holding (however, "narrow" and "specific" it may seem at first glance). Surely she should not "buy" an advocate's argument without thinking hard about what it is she is really "buying."

I share the view that a court should rest its judgment on a principle of general significance that produces like results in like cases.⁶¹ If so, how can a judge avoid considering what *other* fact situations not presently before the court are (or are not) like cases?

Suppose a right to physician-assisted suicide for the terminally ill *were* established. Is there any doubt that lawyers would soon appear .n

56. See Gostin, *supra* note 50, at 98. "There remains almost universal agreement in law and medicine," observed Gostin, "that letting die is ethical, while killing is not. No such agreement exists on physician assisted suicide." *Id.*

57. See Miller et al., *supra* note 55, at 120.

58. Sedler, *supra* note 2, at 726.

59. *Id.* at 727.

60. See Sedler, *supra* note 35, at 20, 23.

61. See generally Herbert Wechsler, *Toward Neutral Principles of Constitutional Law*, 73 HARV. L. REV. 1 (1959).

court arguing that (a) the new right could not be limited to the terminally ill, but had to apply as well to others who would experience unacceptable suffering for many years; and that (b) the new right could not be limited to assisted suicide, but had to include active euthanasia, at least for those severely ill patients who were unable to perform the "final act" themselves? If it is appropriate to transcend the "narrow" and "specific" issue presented in a case *once* it is decided, and to start building immediately on its implications, why is it improper to *anticipate* the implications of a *soon-to-be-decided* case and call the court's attention to them?

I am well aware that a court must decide the case before it and not some other one. But as Justice Felix Frankfurter has observed—

that does not mean that a case is dissociated from the past and unrelated to the future. We must decide this case with due regard for what went before and no less regard for what may come after.⁶²

It is plain that proponents of assisted suicide (and active voluntary euthanasia) consider themselves the "liberals" or "civil libertarians" in this debate. In light of this, I find their disdain for the "slippery slope" argument somewhat unbecoming. For in other settings, "liberals" have been quick to make similar "slippery slope" arguments.

As the author of the leading law review article on "slippery slopes" has pointed out, such arguments appear frequently in discussions about freedom of speech and the rights of those suspected of crime.⁶³ I have little doubt, for example, that Professor Sedler and many other "liberals" defended the Nazis' right to march to Skokie largely because they feared that denying them First Amendment protection might start us down a slippery slope—that "if the swastika and burning crosses are banned today on good grounds, relatively innocuous symbols may be banned tomorrow on not so good grounds."⁶⁴

The *Skokie* case may be viewed as a controversy between "act utilitarians," who wanted to focus on the particular facts of the case, and "rule utilitarians," who preferred to dwell on the long-range implications for the First Amendment of denying the Nazis the right to march. But this time it was clear that the "liberals" were the rule utilitarians.

Only a day before this symposium was held, the *New York Times* reported that a series of killings by terrorists had prompted the Israeli government to authorize harsher interrogation of suspected Muslim

62. *West Virginia State Bd. v. Barnette*, 319 U.S. 624, 660-61 (1943) (Frankfurter, J., dissenting).

63. See Frederick Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361 (1985).

64. JOEL FEINBERG, *OFFENSE TO OTHERS* 92-93 (1985); see also Schauer, *supra* note 63, at 363.

militants and that this decision had aroused the ire of various human-rights groups.⁶⁵ The Israeli government supported its position by pointing to dramatic individual cases. It made what has been called the "ticking bomb" argument—underscoring the need to resort to torture to extract information that could prevent imminent killings.⁶⁶ But a goodly number of Israeli "liberals" were unpersuaded that a very few dramatic cases justified an exception to the absolute ban against torture. They feared that once a crack appeared in the flat prohibition against torture, the crack would gradually widen. Most interrogation situations, they emphasized, were "a far cry" from the "ticking bomb" case.⁶⁷ This controversy, too, may be viewed as one between "act utilitarians" and "rule utilitarians." And once again the "rule utilitarians"—those making the slippery slope argument—were the "liberals."⁶⁸

I am well aware that, as Sissela Bok observed a quarter-century ago, "slippery slope" or, as they are often called, "thin edge of the wedge" arguments have been "used so often and for such dubious purposes that they tend to be brushed aside as merely rhetorical."⁶⁹ But, added Professor Bok, if these arguments are seen as "expressions of caution in the face of unknown future changes, there must be times when the caution has turned out to be justified."⁷⁰ The overuse or misuse of the slippery slope or wedge argument on some occasions does not justify its dismissal in other settings. Whenever such arguments are deployed, "it will be necessary to test the reasonableness of such a use within the context of the specific conflict."⁷¹

65. Joel Greenberg, *Israel Permits Harsher Interrogation of Militants*, N.Y. TIMES, Nov. 17, 1994, at A6.

66. See *id.*

67. See *id.*

68. One might argue that if a "ticking bomb" case actually arose, the legal system would somehow allow torture through the use of some subterfuge. Even so, it does not follow that the "absolute prohibition" against torture should be repealed. It is much easier to justify torture if one approaches the problem generally by balancing the "interest" in banning torture against the "interest" in peace and order. On the other hand, by refusing to acknowledge that we should balance the costs and benefits of torture as a general matter, we strengthen the presumption against torture and increase the likelihood that it will only be resorted to in the rarest and most compelling situations. See the discussion in GUIDO CALABRESI, *IDEALS, BELIEFS, ATTITUDES, AND THE LAW* 167 n.240 (1985) and Charles L. Black, Jr., *Mr. Justice Black, the Supreme Court, and the Bill of Rights*, HARPER'S MAG., Feb. 1961, at 63, 67-68. Both commentators discuss how we should go about deciding whether the police may torture a prisoner to get him to reveal the location of a nuclear bomb when the police knew he has hidden the bomb somewhere in a major city and the bomb is due to explode in a very short time.

69. Sissela Bok, *The Leading Edge of the Wedge*, HASTINGS CENTER REP., Dec. 1971, at 9.

70. *Id.*

71. *Id.*

I submit that the experience in the Netherlands suggests that the use of the "slippery slope" argument is reasonable in the context of assisted suicide and active euthanasia.

A survey commissioned by the Dutch government revealed that in 1990 (the year covered by the survey) there were 1,000 cases of active, intentional termination of life without an explicit request from the patient (nonvoluntary euthanasia).⁷² As would be the case in the United States if current proposals were put into effect, the Dutch guidelines for assisted suicide and active euthanasia "are dependent upon the willingness of doctors to report what they do."⁷³ But "it is evident that most do not, and certainly not those substantial numbers who engage in nonvoluntary euthanasia."⁷⁴

Recently, in the Assen case (a case referred to by the name of the city where it was tried), the Dutch Supreme Court extended the nation's toleration for assisted suicide and euthanasia to patients who are suffering psychological distress, but not physical (let alone terminal) illness.⁷⁵ As Professor Herbert Hendin, the Executive Director of the American Suicide Foundation, and a close observer of the Dutch scene, has recently pointed out:

[T]he Assen case seemed to justify the concerns here as in the Netherlands of a "slippery slope" that moves society inexorably from assisted suicide to euthanasia, from euthanasia for the terminally ill to patients who are chronically ill, from physical suffering to mental suffering, from voluntary requests for euthanasia to killing at the discretion of the physician.⁷⁶

When it comes to assisted suicide (and active euthanasia) the United States is a considerable distance behind (or should one say, ahead of) the Dutch. But developments in this country have not been insignificant. "[I]n only a few years, the debate over euthanasia has moved from acceptance of 'foregoing life-support' to serious consideration of lethal acts."⁷⁷ But we need not focus on this recent development. Back in 1988, some time *before* the legal assault on the distinction between active killing and "letting die" really got underway, Professor Laurence Tribe observed:

72. See Callahan & White, *supra* note 44; Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 ISSUES IN L. & MED. 123, 155 (1994); John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope*, in EUTHANASIA EXAMINED 261, 269, 275-76 (John Keown ed., 1995). See generally CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991).

73. Callahan & White, *supra* note 44.

74. *Id.*

75. See Hendin, *supra* note 72, at 123.

76. *Id.* at 124.

77. Albert R. Jonsen, *Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 459, 467 (1995).

Recent court decisions have rejected many of the distinctions commentators have proposed in earlier discussions about the right to die: not only the distinction between ordinary and extraordinary . . . treatment, but also the distinction between actively hastening death by terminating treatment and passively allowing a person to die of a disease, between withholding and withdrawing life-sustaining treatment, and between the termination of artificial feedings and the termination of other forms of life-sustaining treatment.⁷⁸

If, as has well been said, "the history of our activities and beliefs concerning the ethics of death and dying is a history of lost distinctions of former significance,"⁷⁹ what reason is there to think that history will come to an end when we sanction assisted suicide for the terminally ill? What reason is there to doubt that once we cross the bridge between the termination of life-saving medical treatment and the active intervention of another to bring about death, other lines of demarcation will soon become other "lost distinctions of former significance"?

SUICIDE AND ASSISTED SUICIDE VS. "LETTING DIE"

Professor Sedler has challenged those of us who are opposed to any relaxation of the ban against assisted suicide to defend, "*in terms of constitutional doctrine and precedent*," the distinction between the right to die by refusing life-sustaining medical treatment and the right to die by enlisting the aid of another in committing suicide.⁸⁰ In response, I should like to make several points.

First of all, "the major Anglo-American medical associations vigorously maintain this distinction today"⁸¹ and most courts have had little difficulty grasping its legal significance.⁸² "As these courts have recognized, the fact that the refusal of treatment and assisted suicide may both lead to death does not mean that they implicate identical constitutional concerns."⁸³

78. LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1364-65 (2d ed. 1988).

79. Thomas Mayo, *Constitutionalizing the "Right to Die"*, 49 MD. L. REV. 103, 144 (1990).

80. See Sedler, *supra* note 2, at 729.

81. Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 SEATTLE U. L. REV. 509, 517 (1995) and medical groups cited therein. See also Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 837-38 (1995).

82. See NEW YORK STATE TASK FORCE REPORT, *supra* note 8, and cases collected therein.

83. *Id.* at 71.

In *Cruzan*,⁸⁴ the only "right to die" case ever decided by the United States Supreme Court, the Court "assume[d]" for purposes of the case that a competent person had "a constitutionally protected right" to refuse lifesaving treatment (even nutrition and hydration if artificially delivered).⁸⁵ Nevertheless, the Court seemed to take for granted the constitutionality of laws totally prohibiting assisted suicide. The Court supported its assertion that a state has an undeniable interest in the protection and preservation of human life—even the life of a person in a persistent vegetative state⁸⁶—by noting:

As a general matter, the states—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a state is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.⁸⁷

I share the view that this passage appears to endorse laws prohibiting assisted suicide (as well as laws permitting state intervention to prevent suicide).⁸⁸

A recent statement by the Coordinating Council on Life-Sustaining Medical Treatment Decision Making by the Courts typifies the way many courts and commentators have defended the line between "letting die" and actively intervening to promote or to bring about death:

There are significant moral and legal distinctions between letting die (including the use of medications to relieve suffering during the dying process) and killing (assisted suicide/

84. *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). Although various participants in the debate on death and dying have disagreed about the meaning of some of the language in Chief Justice Rehnquist's majority opinion and Justice O'Connor's concurring opinion in *Cruzan*, the basic facts of the case and its outcome in the United States Supreme Court are worth keeping in mind: Nancy Cruzan was in a persistent vegetative state. Her parents wanted, and claimed they had the right, to terminate the artificial feeding that was keeping their daughter alive. However, Ms. Cruzan had not executed a "living will" or otherwise left clear instructions for ending lifesaving treatment in such circumstance. Because there was no "clear and convincing" evidence of Ms. Cruzan's wishes, the Missouri Supreme Court rebuffed Ms. Cruzan's parents. The United States Supreme Court upheld the state supreme court, *id.* at 282: "In our view, Missouri has permissibly sought to advance [its interest in the preservation of human life] through the adoption of a 'clear and convincing' standard of proof to govern such proceedings."

85. *See id.* at 279.

86. *See id.* at 280.

87. *Id.*

88. *See* Louis Michael Seidman, *Confusion at the Border: Cruzan, "The Right to Die," and the Public/Private Distinction*, 1991 SUP. CT. REV. 47, 53, 62; *see also* Larson, *supra* note 81, at 511-12.

euthanasia). In letting die, the cause of death is seen as the underlying disease process or trauma. In assisted suicide/euthanasia, the cause of death is seen as the inherently lethal action itself.⁸⁹

This "bare bones" statement of the argument becomes much more persuasive, I think, when Daniel Callahan, the director and co-founder of the renowned Hastings Center, explicates and amplifies it:

[T]here must be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology. Nothing but the action of the doctor giving the lethal injection is necessary to bring about death.

* * *

[A judgment that further life-extending treatment is futile] . . . is not principally a judgment about a patient's life at all. It is, instead, a judgment about the limits of medical skills in providing further patient benefit. It is a way of saying that, because the limits of those skills have been reached, the patient may be allowed to die.

To call these judgments, and the ensuing omission of treatment, "intending" death distorts what actually happens . . .

[I]f I stop shovelling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby *intending* a driveway full of snow?

Since death is biologically inevitable sooner or later, not a consequence of our actions but outside of them, we can hardly be said to "intend" death when we admit we can no longer stop it.⁹⁰

As Dr. Callahan suggests, "the refusal of life-sustaining treatment is an integral dimension of medical practice . . ." ⁹¹ Indeed, as Callahan suggests, it is an indispensable part of medical practice. The distinction between "killing" and "letting die" may not be perfectly logical, but, unlike assisted suicide or euthanasia, letting a patient die at some point is a practical condition upon the successful operation of medicine.

A society which *prohibited the refusal* of life-sustaining treatment and enforced such a prohibition with any regularity would not be a pleasant place in which to die (or live). Vast numbers of patients would be "at the mercy of every technological advance."⁹² If people

89. GUIDELINES FOR STATE COURT DECISION MAKING IN LIFE-SUSTAINING MEDICAL TREATMENT CASES 145 (rev. 2d ed. 1993).

90. CALLAHAN, *supra* note 26, at 77-78.

91. See NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 74.

92. *Id.* at 75. As the Task Force observed:

[I]t is estimated that approximately 70 percent of all hospital and nursing home deaths follow the refusal of some form of medical intervention. A

could decline possibly lifesaving treatment but not discontinue it once initiated, many would probably not seek such treatment in the first place. In short, as one commentator recently put it, "the only way we can offer patients and doctors the chance to prolong life—use life-sustaining treatment—is by also allowing them to decide when to cease such efforts"⁹³

A prohibition against the refusal of life-sustaining treatment would not only impose a burden on many more people than does a ban on assisted suicide,⁹⁴ but would impose a far more severe burden. Although it closes "[a]n avenue of escape," a ban on assisted suicide does not totally occupy a person's life or make "affirmative use of his body."⁹⁵ However, to deny a person the right to be disconnected from artificial life-support is to force one into

a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals. It is a life almost totally occupied. The person's body is, moreover, so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of existence—such as breathing, digesting, and circulating blood—are forced upon him by an external agency.⁹⁶

prohibition on the refusal of treatment would therefore require the widespread of restraint of patients unwilling to submit to invasive procedures at the end of their lives.

Id. at 74-75 (footnote omitted).

93. Giles R. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 SEATTLE U. L. REV. 473, 481 (1995).

94. [T]o the extent that laws prohibiting assisted suicide and euthanasia impose a burden, they do so only for individuals who make an informed, competent choice to have their lives artificially shortened, and who cannot do so without another person's aid. As studies have confirmed, very few individuals fall into this group, particularly if appropriate pain relief and supportive care are provided.

NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 72.

95. See Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 795 (1989). Actually, Professor Rubenfeld is writing about suicide, not assisted suicide. But there no longer are any criminal laws in this country prohibiting suicide or attempted suicide. A ban on assisted suicide only imposes a burden on those individuals who want to end their lives and cannot do so without another's aid. Evidently very few people fall into this group. See discussion *supra* note 94.

96. Rubenfeld, *supra* note 95, at 795. *Cruzan*, 497 U.S. at 287-88: (O'Connor, J., concurring) (citation omitted):

As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause. . . . The State's imposition of medical treatment on an unwilling

I share the view of the New York State Task Force on Life and the Law that it is "this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment."⁹⁷

Moreover, as Professor Seth Kreimer has observed, so far as the dangers of mistake or abuse are concerned, "a right to refuse treatment puts at risk only the lives of those who would die without treatment," but "the approval of active euthanasia or assisted suicide would extend the risk to the entire population."⁹⁸ Adds Kreimer:

Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy. The quantitative distinction between some and all can be a legitimate predicate for the qualitative distinction between permission and prohibition.⁹⁹

I realize that many do not consider the arguments made in defense of the distinction between suicide/assisted suicide and the refusal of life-saving treatment completely satisfying. But the distinction between active killing or active intervention to bring about death and "letting die" has more to commend it than mere logic.

For one thing, the distinction represents an historical and pragmatic compromise between the desire to let seriously ill people carry out their wishes to end it all and the felt need to protect the weak and the vulnerable. As Dean (now Judge) Guido Calabresi has observed, when we must make tragic choices—choices that confront us when fundamental beliefs clash—we seek solutions that "permit us to assert

competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion.

97. NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 71 (footnote omitted); see also Scofield, *supra* note 93, at 478 (footnote omitted):

The right not to be touched against one's wishes is the value that underlies the principle of self-determination protected under the law in the name of the "right to die." In the world of philosophy and ethics, this has meant respecting a patient's negative right of noninterference—the right to be let alone. Respecting that right requires forbearance; we must either not initiate treatment or withdraw a treatment we have initiated. Whichever it is, we are to back off.

Where the "right-to-die" consists of physician-assisted suicide, respecting this right requires doctors to assist, not desist. Medical forbearance simply will not produce the desired result.

98. Kreimer, *supra* note 81, at 841.

99. *Id.*

that we are cleaving to both beliefs in conflict."¹⁰⁰ As good an example as any of what Judge Calabresi had described is the way we have dealt with the law and ethics of death and dying.

On the one hand, we want to respect patients' wishes, relieve suffering, and put an end to seemingly futile medical treatment. Hence we allow patients to refuse life-sustaining treatment. On the other hand, we want to affirm the supreme value of life and to maintain the salutary principle that the law protects all human life, no matter how poor its quality. Hence the ban against assisted suicide and active voluntary euthanasia.

I venture to say that one of the purposes of the distinction between the termination of life support and assisted suicide (or active voluntary euthanasia)—or at least one of its principal effects—is to have it both ways. The two sets of values are in conflict, or at least in great tension. Nevertheless, until now at any rate, we have tried to *honor both sets*.

I realize that drawing a line between assisted suicide (or active voluntary euthanasia) and "letting die" will not please every logician or philosopher. But what line will?

This brings us to another factor at work in this area—a factor that I think accounts for a good deal of the support for maintaining the "historic divide" between "active killing" and "letting die."¹⁰¹ Unless we carry the principle of "self-determination" or "personal autonomy" or "control of one's own destiny" to its ultimate logic—assisted suicide (and active euthanasia) by any competent individual who firmly requests it for any reason *the individual* deems appropriate—we have to draw a line *somewhere* along the way. But *where*? I submit that *no* intermediate line, certainly not the one Sedler and his colleagues suggest, would be any more defensible than the one we have now. So why cross the line we have now?

I suspect that few, if any, have ever been in a better position than Wayne County Circuit Judge Richard Kaufman to appreciate the difficulties involved in drawing what I have called an "intermediate line." In late 1993, Judge Kaufman became the first American judge ever to hold squarely that there is a constitutional right to assisted suicide (under certain conditions).¹⁰² Although his decision was ultimately

100. CALABRESI, *supra* note 68, at 88; *cf. id.* at 87-91. See also GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 172-77 (1982).

101. *Cf.* Albert W. Alschuler, *Reflection*, in ACTIVE EUTHANASIA, RELIGION, AND THE PUBLIC DEBATE 105, 108 (Martin Marty & Ron Hamel eds., 1991) (a publication of The Park Ridge Center).

102. *People v. Kevorkian*, No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Wayne County Dec. 13, 1993). Judge Kaufman's opinion is discussed at considerable length in Kamisar, *The Last Bridge to Active Voluntary Euthanasia*, *supra* note 48, at 240-44.

Professor Sedler and his ACLU colleagues were not directly involved in this case. The ACLU and Dr. Jack Kevorkian have kept at some considerable distance from each other.

overturned,¹⁰³ even his critics (and I am one of them) concede that Judge Kaufman wrote a long, thoughtful, well-documented opinion.

I deem it noteworthy that Judge Kaufman drew a line *neither* (a) between terminally ill people seeking to die by suicide and others wishing to do so *nor* (b) between those experiencing severe "pain and suffering" and others whose pain and suffering was, or could be, brought under control. Rather, Judge Kaufman drew the "intermediate line" between the presence and absence of an "objective medical condition" that was "extremely unlikely to improve."¹⁰⁴

If an individual's quality of life was significantly impaired by such a medical condition, even though it was not a life-threatening condition, the individual could exercise the newly established constitutional right. But if an individual's quality of life was significantly diminished for any other reason (e.g., disgrace, financial ruin, the death of a spouse), she could not invoke the constitutional right—no matter how competent she was or firm her desire to die.¹⁰⁵

Although there was some confusion about this, the line Judge Kaufman wound up drawing was *not* a line between "rational" and "irrational" suicide. Rather, it was a line between *one category* of "rational" suicide—where the would-be suicide's life was significantly impaired by an irreversible medical condition—and *other categories* of "rational" suicide.

Judge Kaufman did not draw the line simply between rational and irrational suicide because he feared that "any form of *rational* suicide that did not include the presence of an objective medical condition would be *too close* to irrational suicide."¹⁰⁶ If constitutional protection were extended to *all* persons who harbored a rational wish to die, he told us, "the possibility that irrational suicide would increase is too great."¹⁰⁷ Therefore, according to Judge Kaufman, a state not only has the power to prohibit all classes of "irrational" suicide and assisted suicide, but some classes of "rational" suicide and assisted suicide as well (those where one's quality of life has not been impaired by an objective medical condition).

Judge Kaufman made a valiant effort to find a sensible legal solution to an excruciatingly hard problem. But if a judge can deny constitutional protection to *some* forms of "rational" assisted suicide out of

103. In May of 1994 a two to one majority of the Michigan Court of Appeals ruled that there was no constitutional right to assisted suicide, *Hobbins v. Attorney Gen.*, 518 N.W.2d 487 (Mich. Ct. App. 1994), and seven months later a five to two majority of the Michigan Supreme Court announced its agreement with the court of appeals on this point. *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994) (consolidated with *Hobbins*), *cert. denied*, 115 S. Ct. 714 (1995).

104. *Kevorkian*, No. 93-11482, 1993 WL 603212, at *18-19.

105. *See id.* at *19.

106. *Id.* at *18 (emphasis added).

107. *Id.*

concern that unless this is done "irrational" assisted suicide might get out of hand, why can't a legislature prohibit *all* forms of "rational" assisted suicide on the same grounds?

After all, geriatric psychiatrists (who work with suicidal people every day) and suicidologists (who perform "psychological autopsies" of people who commit suicide) tell us that a suicide rarely occurs in the absence of a major psychiatric disorder, and that this observation holds for suicides among the elderly.¹⁰⁸ Moreover, these experts underscore the inability of depressed persons to recognize the severity of their own symptoms and the failure of primary physicians to detect major depression, especially in elderly patients.¹⁰⁹

As one authority has observed, we encourage suicide among the elderly "by our neglect and indifference."¹¹⁰ As another commentator has put it, "[s]uicidal persons are succumbing to what they experience as an overpowering and unrelenting coercion in their environment to cease living."¹¹¹ Is it not fair to assume that these pressures will intensify in a society that sanctions assisted suicide (and thereby suicide as well)? Is it not fair to assume that once assisted suicide is a lawful alternative and people are "doing it," and feel free to talk about it, more people, especially the sick, the old and the vulnerable, will see this route as a tempting way to spare both oneself and one's family and friends the burden of serious illness and/or advanced age?¹¹²

THE "ABORTION CASES": HOW EXPANSIVE IS THE CONCEPT OF PRIVACY?

Professor Sedler and his allies find support for their views in the Supreme Court's abortion cases.¹¹³ In *Roe v. Wade*,¹¹⁴ the Court informed us that a "right of privacy," which had earlier been invoked to strike down restrictions on the use and distribution of contracep-

108. See James H. Brown, et al., *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 AM. J. PSYCHIATRY 208, 210 (1986); Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 NEW ENG. J. MED. 1100, 1101 (1991); Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 AM. J. PSYCHIATRY 143 (1993); Roberta Richardson, et al., *Coping with the Suicidal Elderly: A Physician's Guide*, GERIATRICS, Sept. 1989, at 43-44.

109. See David C. Clark, "Rational" Suicide and 'People with Terminal Conditions or Disabilities', 8 ISSUES IN L. & MED. 147, 155, (1992); Conwell & Caine, *supra* note 108, at 1101.

110. GEORGE H. COLT, *THE ENIGMA OF SUICIDE* 394 (1991).

111. *Id.* at 342 (quoting MENNO BOLDT, *THE RIGHT TO SUICIDE* (1985) (Suicide Information and Education Centre Current Awareness Bulletin, 1 (2), at 1)).

112. For a discussion of "circumstantial" and "societal" manipulation in the context of suicide, see M. Pabst Battin, *Manipulated Suicide*, in *SUICIDE: THE PHILOSOPHICAL ISSUES* 169 (M. Pabst Battin & David J. Mayo eds., 1980).

113. See Sedler, *supra* note 2, at 728-733. See also Sedler, *supra* note 35, at 23-24.

114. 410 U.S. 113 (1973).

tives,¹¹⁵ "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."¹¹⁶ The Court cleared the way for its ultimate holding by rejecting the state's argument that "a fetus is a person" within the meaning of the Constitution—"the word 'person', as used in the Fourteenth Amendment, does not include the unborn."¹¹⁷ Although *Roe* did not involve the termination of a human life (so far as the Court was concerned), Sedler and others have read the case and its progeny very broadly to support a "right" or "liberty," under certain circumstances, to enlist the assistance of others in committing suicide.¹¹⁸

I agree with Professor Sedler that the constitutional answer to the question he and his colleagues pose "must be found in applicable Supreme Court doctrine and precedent."¹¹⁹ But *what* are the relevant precedents? (Why, for example, does Sedler totally ignore *Bowers v. Hardwick*,¹²⁰ a case which, so long as it remains on the books, greatly reduces *Roe*'s potential for expansion?) And *how* should we characterize the applicable doctrine?

"The laws struck down under the rubric of privacy have had a peculiar tendency to gravitate around sexuality"¹²¹—"not 'sex' as such, of course, but sexuality in the broad sense of that term: the network of decisions and conduct relating to the conditions under

115. See *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

116. *Roe*, 410 U.S. at 152-53. But the right is not absolute. *Id.* at 162-66. As a general proposition, after fetal viability the state may proscribe abortion. *Id.* at 164-65. As a general matter, before viability the state may not. *Id.* at 163-64. But "the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman" *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2804 (1992) (emphasis added).

Suppose, because of a pregnant woman's special disability or particular illness, an abortion before fetal viability can only be performed at great risk to her life. Suppose, further, that the woman still wants an abortion. I take it that under such circumstances the state could prevent the abortion from being performed despite the woman's wishes.

If so, if a state can override a woman's choice when the abortion she desires would jeopardize her life, does it not follow that, consistently with the abortion cases, a state can ban a so-called medical procedure intended to and designed to end a person's life? Does it not follow, too, that a state can block the active intervention of a physician trying to promote or to bring about a patient's death? See Marc Spindelman, *Roe vs. Wade Recognizes No 'Right to Die'*, DETROIT NEWS, Oct. 16, 1994, at 3B.

117. *Roe*, 410 U.S. at 157-58.

118. See *supra* note 113 and accompanying text.

119. Sedler, *supra* note 2, at 728.

120. 478 U.S. 186 (1986) (upholding prohibition against consensual sodomy as applied to homosexuals, even though the activity took place in private).

121. Rubenfeld, *supra* note 95, at 738.

which sex is permissible, the social institutions surrounding sexual relationships, and the procreative consequences of sex."¹²²

Although the plaintiffs in *Roe* and its companion case¹²³ did not even challenge the abortion restrictions as sex discriminatory, a growing number of commentators, including Judge (now Justice) Ruth Bader Ginsburg,¹²⁴ have maintained that the best argument for the right to abortion is based on principles of "sex equality," not "due process" or "privacy."¹²⁵ As then Judge Ginsburg noted (in a lecture delivered shortly before her nomination to the United States Supreme Court), in *Planned Parenthood v. Casey*,¹²⁶ which reaffirmed *Roe*, the majority "added an important strand to the Court's opinions on abortion"—it "acknowledged the intimate connection between a woman's 'ability to control [her] reproductive li[fe]' and her 'ability [to] participate equally in the economic and social life of the Nation.'"¹²⁷

"Laws restricting abortion so dramatically shape the lives of women, and only of women," Professor Laurence Tribe has observed,

122. *Id.* at 744. See also RICHARD A. POSNER, SEX AND REASON 325 (1992):

In a series of decisions between 1965 and 1977 [*Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Roe v. Wade*, 410 U.S. 113 (1973); and *Carey v. Population Services International*, 431 U.S. 678 (1977)], the Supreme Court created a constitutional right of sexual or reproductive autonomy, which it called privacy.

All four cases, adds Judge Posner, *id.* at 343, can be "viewed as decisions motivated by a concern with the burdens of unwanted pregnancy, a concern that resonates with the women's movement and thus connects with the Court's decisions invalidating sexually discriminatory legislation under the equal protection clause"

123. *Doe v. Bolton*, 410 U.S. 179 (1973).

124. See Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199-1202 (1992); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 382, 386 (1985).

125. See CALABRESI, *supra* note 68, at 99-102; CASS R. SUNSTEIN, THE PARTIAL CONSTITUTION 272-85 (1993); TRIBE, *supra* note 78, at 1353-55; Kenneth L. Karst, *Foreword: Equal Citizenship Under the Fourteenth Amendment*, 91 HARV. L. REV. 1, 57-59 (1977); Kreimer, *supra* note 81, at 849; Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1319 (1991); Frances Olsen, *Unraveling Compromise*, 103 HARV. L. REV. 105, 117-26 (1989); Giles R. Scofield, *Rethinking Roe*, 8 TRENDS IN HEALTH CARE, L. & ETHICS 17, 19-20 (Summer, 1993); Reva Siegel, *Reasoning From the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 350-80 (1992); David A. Strauss, *Abortion, Toleration and Moral Uncertainty*, 1992 SUP. CT. REV. 1, 18-22. See also POSNER, *supra* note 122, at 339-40 (recognizing that "focus" of *Roe*'s legal defenders has "shifted to the equal protection clause," but questioning the adequacy of this approach); cf. Donald H. Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569, 1618-42 (1979) (contending that a pregnant woman is a "potential Samaritan" vis-a-vis her fetus, and should not be treated differently from other potential Samaritans).

126. 505 U.S. 833 (1992).

127. Ginsburg, *Speaking in a Judicial Voice*, *supra* note 124, at 1199 (quoting *Casey*, 505 U.S. at 856). On this point, the controlling Justices in *Casey* (O'Connor, Kennedy and Souter, JJ.) spoke for the Court. See also 505 U.S. at 928 (Blackmun, J., concurring): "[A] State's restrictions on a woman's right to terminate her pregnancy also implicate constitutional guarantees of gender equality."

"that their denial of equality hardly needs elaboration."¹²⁸ Continues Tribe:

While men retain the right to sexual and reproductive autonomy, restrictions on abortion deny that autonomy to women. Laws restricting access to abortion thereby place a real and substantial burden on women's ability to participate in society as equals. Even a woman who is not pregnant is inevitably affected by her knowledge of the power relationships created by a ban on abortion.¹²⁹

The more the right to abortion is grounded on "sexual equality," or the more *Roe* is justified on that basis, the less comfort that right offers proponents of a constitutional right to assisted suicide. But even those who continue to view the right to abortion as based on "privacy" or "personhood" must take into account how the scope and meaning of these rather abstract concepts are affected by the decision in *Bowers v. Hardwick*.¹³⁰

I would not have joined Justice White's opinion for the Court in *Hardwick*. I agree with former Solicitor General Charles Fried that the opinion White wrote upholding the constitutionality of a state law criminalizing consensual sodomy, as applied to homosexuals, is "stunningly harsh and dismissive."¹³¹ But Justice White spoke for five members of the Court. Any discussion of the breadth and potential for expansion of such concepts as "privacy" and "personhood" which ignores *Hardwick* (as does Professor Sedler, and as did Judge Rothstein when she invalidated an anti-assisted suicide law)¹³² is seriously incomplete.

"The Court is most vulnerable and comes nearest to illegitimacy," observed the *Hardwick* Court, per Justice White, "when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution."¹³³ More specifically, the Court's prior "privacy" cases had recognized three categories of protected activity—marriage, procreation, and family relationships—but "[n]o connection" between "homosexual activity" and any of these categories was demonstrated.¹³⁴

As Professor Jed Rubenfeld has observed:

128. LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 105 (1990).

129. *Id.*

130. *See* 478 U.S. at 186.

131. CHARLES FRIED, *ORDER AND LAW* 82 (1991). For powerful criticism of *Hardwick*, see TRIBE, *supra* note 78, at 1421-35. As Professor Tribe acknowledges, he argued the case in the Supreme Court for the losing party.

132. *See supra* note 28 and accompanying text.

133. 478 U.S. at 194.

134. *Id.* at 191.

Justice White neither sought nor found any unifying principle underlying his three categories. It was as if the Court had said, "We in the majority barely understand why even these three areas are constitutionally protected; we simply acknowledge them and note that they are not involved here." The device of compartmentalizing precedent is an old jurisprudential strategy for limiting unruly doctrines. The effect here is that, after *Hardwick*, we know that the right to privacy protects some aspects of marriage, procreation, and child-rearing, but we do not know why. By identifying three disparate applications ungrounded by any unifying principle, the majority effectively severed the roots of the privacy doctrine, leaving only the branches¹³⁵

I do not deny that a colorable argument may be made that the "right of privacy" invoked in *Roe* includes the "right" or "liberty" of a person to choose whether to continue to live until death comes naturally or to hasten death by obtaining the active intervention of another. But a *much stronger* argument may be made, I think, that the "right of privacy" encompasses the autonomy of sexual activity and relationships.

As Justice Blackmun wrote in *Hardwick*, "sexual intimacy is 'a sensitive, key relationship of human existence, central to . . . the development of human personality'"; "individuals define themselves in a significant way through their intimate sexual relationships with others" and "much of the richness of a relationship will come from the freedom an individual has to *choose* the form and nature of these intensely personal bonds."¹³⁶ But Justice Blackmun wrote in dissent.

I share Justice Blackmun's view that before it can punish its people for their actions, a state "must do more than assert that the choice they have made is an 'abominable crime not fit to be named among Christians.'"¹³⁷ I agree, too, with another *Hardwick* dissenter, Justice Stevens, that "the fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice"¹³⁸ However, as the recent report of the New York State Force on Life and the Law well demonstrates, any state that prohibits assisted suicide can advance justifications for its legislation that go well beyond the law's conformity to religious doctrine or "morality."¹³⁹

135. Rubinfeld, *supra* note 95, at 748-49. See also POSNER, *supra* note 122, at 341 (asserting that *Hardwick* "froze the constitutional right of privacy").

136. 478 U.S. at 205 (Blackmun J., joined by Brennan, Marshall and Stevens, JJ., dissenting).

137. *Id.* at 199-200.

138. 478 U.S. at 216 (Stevens, J., joined by Brennan and Marshall, JJ., dissenting).

139. Among the reasons the Task Force gave for resisting even a very limited form of physician-assisted suicide (or active voluntary euthanasia) were:

In *Planned Parenthood v. Casey*,¹⁴⁰ in the course of reaffirming *Roe*, the Court spoke at one point about "the right to define one's own concept of existence" and one's concept of "the mystery of human life" as being "at the heart of liberty."¹⁴¹ As did Judge Rothstein in *Compassion in Dying*,¹⁴² Sedler finds much solace in this capacious language.¹⁴³ The language constitutes the last two sentences of a long paragraph. I would like to quote the entire paragraph, including the first four sentences:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Our precedents "have respected the private realm of family life which the state cannot enter." *These matters*, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty

[1] Illness is a quintessential state of vulnerability [and] patients bring this vulnerability to their relationship with physicians As with other "treatments" judgments about when and for whom assisted suicide and euthanasia are provided would be managed principally by physicians, not their patients.

NEW YORK STATE TASK FORCE REPORT, *supra* note 8, at 121.

[2] In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable, [especially] for those who are elderly, poor, socially disadvantaged, or without access to good medical care.

Id. at ix.

[3] Out of benevolence or from sheer frustration or exhaustion, [relatives] may suggest or encourage the patient to accept assisted suicide or euthanasia [and] [m]otivated by a sense of guilt or abandonment, many patients will feel that they have no choice once the option is presented. Indeed, if [these options] are widely available, patients may feel obligated to consider [them] to alleviate the burden their illness and continued life imposes on those closest to them.

Id. at 124. And finally,

[4] [A]ssisted suicide and euthanasia are closely linked; as [shown by the experience in the Netherlands, where a lethal injection is preferred by both doctors and patients,] once assisted suicide is embraced, euthanasia will seem only a neater and simpler option to doctors and their patients.

Id. at 145 (footnote omitted). See also *supra* notes 14-15 and accompanying quotations from the NEW YORK STATE TASK FORCE REPORT.

140. 505 U.S. 833 (1992).

141. *Id.* at 851.

142. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1459-61 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995). The Chief Judge and ten other members of the Ninth Circuit are scheduled to rehear this case *en banc*. 62 F.3d 299 (1995).

143. See Sedler, *supra* note 2, at 728.

protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.¹⁴⁴

This paragraph does contain some sweeping language. But I think such language can plausibly be read as explaining why "*these matters*"—"personal decisions relating to marriage, procreation, contraception" and "family relationships" or, more summarily, "the private realm of family life"—*have been given* constitutional protection.

Viewed in isolation, the language about "defin[ing] one's own concept of existence" and "of the mystery of human life" does seem breathtaking. Literally, it *would* cover the right of terminally ill people to enlist the assistance of another in committing suicide. But literally it would also cover the right of *any* competent person—physically ill *or not*—to enlist the aid of another in suicide.¹⁴⁵

Professor Sedler maintains that the right to define one's concept of existence (and to make basic decisions about one's bodily integrity) "surely must include" the right of terminally ill persons to obtain assistance in ending their lives,¹⁴⁶ *but not* the right of anybody else to do so.¹⁴⁷ Why not?

I understand how one can read the passage quoted above narrowly (limiting it to reproductive rights and related matters) or read it broadly (including death and dying). But I fail to see how one can read it the way Sedler does.

If, as Sedler seems to say, the right to "define one's concept of existence" includes the right to end one's existence with the active assistance of another, and if, as he also seems to say, the right to "define one's own concept . . . of the mystery of human life" includes the right to end one's interest in life and its mystery with the active assistance of another, why are these rights limited to the terminally ill? Either the language quoted above refers only to personal decisions relating to marriage, procreation, contraception, child rearing and the like, or it refers to all that plus personal decisions relating to suicide and suicide assistance. If the latter, why doesn't *everybody* have the

144. *Casey*, 505 U.S. at 851 (citations omitted; second emphasis added.)

145. As Judge John Noonan observed for a two to one majority in *Compassion in Dying*:

If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult.

49 F.3d 591.

146. See Sedler, *supra* note 2, at 728.

147. *Id.* at 727.

right to define his concept of existence or his concept of the mystery of life?

Why are these awesome rights denied to the great majority of us because our lives are of "indefinite duration"?¹⁴⁸ Why, if people so wish, can't they *change that*? Why, if they so desire, can't people bring a life of "indefinite duration" to a definite and abrupt close? Is the choice *whether* to end one's life and *how* to do so "central to the liberty protected by the Fourteenth Amendment"¹⁴⁹ or is it not?

A reading of "the right to define one's own concept of existence" language broad enough to cover assisted suicide would be broad enough to cover a great many other things. It would surely cover the autonomy of sexual activity and relationships, and it would do so more easily than it would embrace assisted suicide. Moreover, the connection between "homosexual activity" and the categories of activity already protected by the "privacy" cases seems much closer than the relationship between assisted suicide and categories of activity already protected. So far as I am aware, however, nobody has suggested that *Casey* overrules *Bowers v. Hardwick*.

As a panel of the Ninth Circuit observed, in reversing a federal district judge who had relied heavily on the same spacious language that Sedler and his colleagues do:

The language taken from *Casey*, on which the district court pitched its principal argument, should not be removed from the context in which it was uttered. Any reader of judicial opinions knows they often attempt a generality of expression and a sententiousness of phrase that extend far beyond the problem addressed. . . . To take [a few lines] out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these [few lines] "almost prescriptive" in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request.¹⁵⁰

148. See *id.* at 726-27:

[A]s to assisted suicide, of course the state can constitutionally prohibit assisting a suicide in the ordinary sense of the term—that is, by providing assistance in ending a life that is otherwise of indefinite duration. . . . [T]he principle [that the government has the power to protect us from ourselves] would be relied on by the courts to sustain a ban on assisted suicide in the ordinary sense of the term.

149. See *supra* note 144 and accompanying quote from *Casey*.

150. *Compassion in Dying*, 49 F.3d at 590 (two to one majority per Noonan, J.). As indicated earlier, the Ninth Circuit is scheduled to rehear this case *en banc*. 62 F.3d 299 (1995).

I do not think we should read too much into the soaring language found in one small segment of a long opinion. Although it "pointedly reaffirmed the 'essential holding' of *Roe v. Wade* that abortions prior to fetal viability may not be criminalized,"¹⁵¹ *Casey* "notably retreats from *Roe*."¹⁵² By upholding several provisions of a state act that imposed restrictions on reproductive freedom that "could not have survived strict adherence to *Roe*,"¹⁵³ the Court "once again invited state legislatures to regulate and sharply restrict access to legal abortions."¹⁵⁴

Moreover, in reaffirming *Roe*, the *Casey* majority relied heavily on the rule of *stare decisis*. Absent "the most compelling reason to reexamine a watershed decision," the majority told us, to overrule *Roe* "under fire" would "subvert the Court's legitimacy beyond any serious question."¹⁵⁵

Finally, the three controlling jurists, Justices O'Connor, Kennedy and Souter, (none of whom had been on the Court when *Roe* was decided) made an extraordinary statement:

We do not need to say whether each of us, had we been Members of the Court [when *Roe* was decided], would have concluded, as the *Roe* Court did, that [the weight of the State's interest in protecting the potentiality of life] is insufficient to justify a ban on abortions prior to viability. . . . The matter is not before us in the first instance, and coming as it does after nearly 20 years of litigation in *Roe's* wake we are satisfied that the immediate question is not the soundness of *Roe's* resolution of the issue, but the precedential force that must be accorded to its holding.¹⁵⁶

All things considered, I believe the Court that reaffirmed *Roe* in 1992 was bent on bringing an old constitutional war to an end—not preparing to fight a new one.

A FINAL THOUGHT

"[E]very person in Holland has free access to health care" and thus "concern about America's 34 million uninsured citizens—several times greater than the entire population of Holland—does not come into the picture."¹⁵⁷ Nor do "the feelings, pressures, and fears of mil-

151. Kathleen Sullivan, *Foreword: The Justices of Rules and Standards*, 106 HARV. L. REV. 22, 27 (1992).

152. Ginsburg, *Speaking in a Judicial Voice*, *supra* note 124, at 1208.

153. *Id.* at 1199.

154. *The Supreme Court, 1991 Term*, 106 HARV. L. REV. 19, 201 (1992).

155. 505 U.S. at 851; *see also id.* at 868-69.

156. *Id.* at 871.

157. AHRONHEIM & WEBER, *supra* note 21, at 90-91.

lions of other Americans who may not have adequate coverage to pay for relevant services."¹⁵⁸

I agree with Professor Giles Scofield that —

*The moral issue of our day is not whether to enable or prevent a few individuals' dying in the comfort of their home in the presence of their private physicians. The moral issue of our day is whether to do something about our immoral system of care, in which treatment is dispensed according to a principle best characterized as that of economic apartheid.*¹⁵⁹

As my former colleague, Robert Burt, recently observed, at a time when many millions of Americans lack adequate health care and Congress has refused to do much about it, "it would be ironic if the judiciary selected physician-assisted suicide as the one health care right that deserves constitutional status."¹⁶⁰

158. *Id.* at 91.

159. Scofield, *supra* note 93, at 491.

160. Robert A. Burt, *Death Made Too Easy*, N.Y. TIMES, Nov. 16, 1994, at A15.

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May, 1958

No. 6

Walt Kaminer

At the Crystal Palace Aquarium not long ago I saw a crab euthanatising a sickly fish, doubtless from the highest motives.¹

A recent book, Glanville Williams' *The Socrity of Life and the Criminal Law*,⁹ once again brings to the fore the controversial topic of euthanasia,¹⁰ more popularly known as "mercy killing." In keeping with the trend of the euthanasia movement over the past generation, Williams concentrates his efforts for reform on the involuntary type of euthanasia, for example, the cancer victim begotten for death; as opposed to the *involuntary* variety, that is, the case of the congenitally blind, the permanently insane or the senile.

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1. Anonymous letter to the editor, 46: The Spectator 241 (1823).
2. (1957) (This book is hereinafter referred to as "Williams"). The book is an expanded and revised version of the James S. Carpenter lectures delivered by Professor Williams at Columbia University and at the Association of the Bar of the City of New York in the Spring of 1956. The connecting thread between the two lectures is the theme of the life of the English-speaking peoples, a theme which is to be protected under the criminal law of the United States.

The book was recently lauded by Bertrand Russell, 10 *Stan. L. Rev.* 382 (1958), for more restrained receptions see the interesting and incisive views by Professor William J. Curran, 71 *Harv. L. Rev.* 585 (1958) and Professor Richard C. Donnelly, 67 *Vale L.J.* 753 (1958).

3. Euthanasia has a Greek origin: *euthana* (good) + *thanatos* (death). The term apparently first appeared in the English language in the early seventeenth century in the meaning of a gentle, easy death. The term then came to mean *the doctrine or theory that in certain circumstances death should be painlessly killed, and more recently has come to mean the act or practice of bringing about a gentle and easy death*. In its broad sense, euthanasia embraces a variety of situations, some where the patient is unable of consenting to his death, others where he obviously is not. Thus,

WHERE CAN I
FIND A MUTUAL
SAVINGS BANK?

FARMERS & MECHANICS
6TH & MARQUETTE

Farmers & Mechanics
SAVINGS BANK OF MINNEAPOLIS
MEMBER FEDERAL RESERVE BANK

When a legal scholar of Williams' stature⁴ joins the ranks of such formidable criminal law thinkers as America's Herbert Wechsler and the late Jerome Michael,⁵ and England's Hermann Mannheim⁶ in approving voluntary euthanasia, at least under certain circumstances, a major exploration of the bases for the euthanasia prohibition seems in order.⁷ This need is underscored by the fact that Williams' book arrives on the scene so soon after the stir caused by a brilliant Anglican clergyman's plea for voluntary euthanasia.⁸

The Law On The Books condemns all mercy-killings.⁹ That this two generations ago, H. J. Rose defined the euthanasia circumstances as "when owing to disease, smitthly, or the like, a person's life has ceased to be either agreeable or useful".¹⁰ Encyclopedia of Religion and Ethics 596 (1912). In the 1930's there sprang up organizations in both England and America which dramatized the plight of the patient in "unnecessary" pain and relief of the patient's suffering. The term "unpleasant death" "releasing" the patient from severe physical suffering. Advocate of euthanasia has been called a "euthanasist"; to subject to euthanasia has been called to "euthanatize." These terms will be so used through-out. See generally Fletcher, *Morals and Medicine* 172-73 (1954) Sullivan, *Medical Morality* 11-13 (1958) (originally a dissertation entitled *Catholic Teaching on the Morality of Euthanasia*); Flanks, *Euthanasia*, 161 *Practitioner* 101 (1948).

4. Williams' admirable treatise, *Criminal Law: The General Part* (1953), stamps him as one of the giants in the field.

5. Wechsler and Michael, *A Rationale of the Law of Homicide: I*, 37 *Colum. L. Rev.* 701, 739-40 (1937). Since the article was written before the American Law Institute's *Model Penal Code*, it is conceivable that Prof. Wechsler, who had ample opportunity to study the draft, might have had some reservations about what differently today.

6. Mannheim, *Criminal Justice and Social Reconstruction* 13-17 (1946). Attention have urged complete immunization of voluntary euthanasia. Whether or not it should be regarded as murder, which is now the case, active mitigation, or some lesser degree of criminal homicide. One way to achieve mitigation would be to recognize to "good motive" generally; another would be to make a specific recognition to "good motive" voluntary euthanasia alone. For a discussion of these alternatives, see generally, *Symposium of Civil Liberties: A Legal View* 1, 31 *N.Y.U.L. Rev.* 1223 (1953-54); Sullivan, *Euthanasia: A Study in Comparative Criminal Law* 13-14 (1958); Fletcher, *supra*, note 3 at 172-220 (1954). The Royal Commission on Capital Punishment (1949-53) took the position that "mercy killings" could not frantically be reduced in penalty. See *Report* at 34-40.

7. Fletcher, *supra*, note 3 at 172-220 (1954). The book is quite similar to Williams in that it deals with the moral and legal issues raised by contraception, artificial insemination, sterilization and right of the patient to know the truth. It is the subject of an interesting and stimulating symposium, *Contraception and Sterilization*, 116-124 (1956) by two lawyers, Prof. Harry Kalven and Judge M. L. Hand, and two theologians, Emanuel Rackman and Paul Ramsey; two philosophers, Horace M. Kallen and Joseph D. Hasset; and a physician, L. Phillips Frohman.

8. In Anglo-American jurisprudence a "mercy-killing" is murder. In theory, neither good motive nor consent of the victim is relevant. See, e.g., 2 *Hurdick*, *Law of Crimes* §§ 422, 447 (1946); Miller, *Criminal Law* 55,

has a substantial deterrent effect, even its harshest critics admit.¹¹ Of course, it does not stamp out all mercy-killings, just as murder and rape provisions do not stamp out all murder and rape, but presumably it does impose a substantially greater responsibility on physicians and relatives in a euthanasia situation and turns them away from significantly more doubtful cases than would otherwise be the practice under any proposed euthanasia legislation to date. When a mercy-killing occurs, however, The Law In Action is as malleable as The Law On The Books is uncompromising. The high incidence of failures to indict,¹² acquittals,¹³ suspended sentences¹⁴ and reprieves¹⁵ lend considerable support to the view that—

If the circumstances are so compelling that the defendant ought to violate the law, then they are compelling enough for the jury to violate their oaths. The law does well to declare these homicides unlawful. It does equally well to put no more than the sanction of an oath in the way of an acquittal.¹⁶

The complaint has been registered that "the prospect of a sentimental acquittal cannot be reckoned as a certainty."¹⁷ Of course not. The defendant is not always entitled to a sentimental acquittal. The few American convictions cited for the proposition that the present state of affairs breeds "inequality" in application may be cited as well for the proposition that it is characterized by 172 (1934); Perkins, *Criminal Law* 721 (1957); J. Wharton, *Criminal Law and Procedure* § 194, (Anderson 1957); Orth, *Legal Aspects Relating to Euthanasia*, 2 *Md. Med. J.* 102 (1953) (symposium on euthanasia); 48 *Mich. L. Rev.* 1199 (1950); Anno, 25 *A.L.R.* 1007 (1923).

In a number of countries, e.g., Germany, Norway, Switzerland, a compassionate motive and homicide upon request operate to reduce the penalty. See, e.g., Hildebrandt, *supra*, note 1 at 369 and n. 74. However, apparently only Uruguayan law completely immunizes a homicide characterized by both of the above factors. *Id.* at 369 and n. 74. The Sliving article only contains an interesting and fairly extensive comparative study of assisted suicide and the degree to which it is treated differently from a direct mercy-killing. In this regard see also Friedman, *Sliving and the Law*, 63 *Med. Times* 681 (1957).

10. See Williams, p. 342.

11. See, e.g., the case of Harry C. Johnson, who appropriated his cancer-stricken wife, apparently at her urging. *N.Y. Times*, Oct. 2, 1938, p. 1, col. 3; Oct. 3, 1938, p. 34, col. 3. Various psychiatrists reported that Johnson was "temporarily insane" at the time of the killing, but was "now sane." *N.Y. Times*, Oct. 12, 1938, p. 30, col. 4. A week later, a Nassau County grand jury returned a verdict of insanity. *N.Y. Times*, Oct. 1938, p. 46, col. 1.

12. See, e.g., the *Snowdrift*, *Pugh* and *Brownhill* cases discussed at notes 12-17, 183, *infra*.

13. See e.g., the *Reynolds* case discussed at note 181, *infra*.

14. See e.g., the *Brownhill* and *Long* cases discussed at notes 178-179, *infra*.

15. Curtis, *It's Your Law* 95 (1954).

16. Williams, p. 328.

18. "Not a great many years ago, upon the Norfolk circuit, a larceny was committed by two men in a poultry yard, but only one of them was apprehended; the other having escaped into a distant part of the country, and evaded all pursuit. At the next assizes the apprehended thief was tried, and convicted. But Lord Loughborough, before whom he was tried, thinking he ought to be offence a very slight one, sentenced him only to a few months imprisonment. The news of this sentence having reached the accomplice's trial, he treated the verdict with great contempt, and said, 'I will not be hanged for a larceny of a few chickens, when my friend has been hanged for a larceny of a great deal more than chickens.'"

[illegible]

The existing law on euthanasia is hardly perfect. But if it is not too good, neither, as I have suggested, is it much worse than the rest of the criminal law. At any rate, the imperfections of the existing law are not cured by Williams' proposal. Indeed, I believe adoption of his views would add more difficulties than it would remove.

Williams strongly suggests that "euthanasia can be condemned only according to a religious opinion."²¹ He tends to view the opposing camps as Roman Catholics versus Liberals. Although this was a certain initial appeal to me, a non-Catholic and a self-styled liberal, I deny that this is the only way the battle lines can, or should, be drawn. I leave the religious arguments to the theologians. I share the view that "those who hold the faith may follow its precepts without requiring those who do not hold it to act as if they did."²² But I do find substantial utilitarian obstacles on the high road to euthanasia.²³

giving them [the jury] this dispensing power, but it should be given to them directly and not in a mystifying cloud of words." From the frequency with which the dispensing power is exercised, and the manner in which it is exercised by the press and public generally, it seems fairly clear that nobody mystified very much in the mercy-killing cases.

24. Williams, p. 312. This seems to be the position taken by Derrand in his review of Williams' book (*nyu* para 2 at 382).

22. Wechsler and Michael, *supra* note 5 at 740. *But see* Denning, *The Jurisprudence of Religion*, in *The Changing Law* 99 (1953) ("without religion there can be no morality; and without morality there can be no law"); Lord Justice Denning's assertion is the motif of Fitch, Harding, Katz and Quillian, *Religion, Morality and Law* (1956).

23. I am aware that the arguments set forth, however "reasonable" or "logical" some of them may be, were not the reasons which prompted the prohibition against mercy-killing. I realize, too, that those who are incoherently against any form of euthanasia on religious grounds do not always limit a argument to the religious. See, e.g., Martin, *Euthanasia and Modern Morality*, in The Jurist 47 (1960) 495-507. I think that many non-religious persons in Christianity and paganism, and indeed the vast majority of the human mind, feel the charge that I am here making of an "arbitrary" tendency of the human mind to graft upon an actual course of law the "ought" or even a duty to observe this same course in the future." I agree with the observation in the Function of Law 673-74 (1946): "I would meet this charge with the observation that the law is not a mere rule of conduct. It is a policy with the observable aim of securing the best results for the community that the reasons people give for the law support. It is not only the policies that influence the development of the law, but also the kind of conduct professed by our fathers yesterday are among the reasons of today." M. R. Cohen, *see* Faith of a Lifer 70 (1946).

After all, that the criminal law itself arose to fill the need to regulate

As an ultimate philosophical proposition, the case for voluntary euthanasia is strong. Whatever may be said for and against suicide generally,¹⁴ the appeal of death is immeasurably greater when it is sought not for a poor reason or just any reason, but for "good cause," so to speak; when it is invoked not on behalf of a "socially useful" person, but on behalf of, for example, the pain-racked "hopelessly incurable" cancer victim. *If* a person is *in fact* (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die, I would hate to have to argue that the hand of death should be stayed. But abstract propositions and carefully formed hypotheticals are one thing; specific propositions designed to cover everyday situations are something else again.

In essence, Williams' specific proposal is that death be authorized for a person in the above situation "by giving the medical officer or officers attending him such advice as he may think fit." The obvious self-help and private vengeance, see, e.g., 2 Holdsworth, History of English Law 67-80 (1955) ("the law was not at all clear"), Common Law 2-3, 40-41 (1981); Maine Ancient Law 391-401 (Pollack & Meier, 1936), are also a possible point of origin in "a religious institution of sacrificing an impious wrongdoer to an offending god who might else inflict his wrath upon the whole community," Pound, Criminal Justice in America 54 ("real reasons" of deterrence, incapacitation and rehabilitation no less than the "legal reason" of retribution). And there has been some basis for drafting new codes of attacking one's enemy and its lesser members since the late nineteenth century. But even if the status quo on mercy-killing, both while it lasts and after it ends, is against which we come forth to date.

—

24. Unlike Professor Williams, even many proponents of voluntary euthanasia appear to shrink from suicide as a general proposition. Consider, for example, the following statements made by vice-presidents of England's Voluntary Euthanasia Legalisation Society:

The act of the suicide is wrong because he takes his own life solely on his own judgment. It may be that he does so in a mood of despair or remorse and thus evades the responsibility of doing what he can to repair the wrong or improve the situation. He flings away his life when there is still much to be done. He has moral duties to be fulfilled before he can do the deed. The proposals for Voluntary Euthanasia are still duties to be done with suicide. They take the decision out of the hands of the individual. The case is submitted to the objective judgment of doctors and specially appointed officials whose duty it would be to enquire whether the conditions which constitute the sinfulness of suicide are present or not. Matthews, *Voluntary Euthanasia: The Ethical Aspects* 4-5 (Address by the President of the Royal Society of Medicine, 1950). See also Voluntary Euthanasia Evaluation Society Annual Meeting, 1950 (London, 1950) (disputed by the Christian and Jewish Societies).

In respect of each of its citizens, the State has made an investment of substantial amount, and as a mere matter of business it is entitled to demand an adequate return. If a useful citizen, by taking his life, diminishes that return, he does an anti-social act to the detriment of the community as a whole. We cannot carry the doctrine of isolation to the extent of saying that we live unto ourselves. Hence it appears on purely rationalistic grounds that the State is entitled to discontinue suicide.

Larenz, *1 Österr. Juratissen*, 8 *Medico-Legal Rev.* 91, 92 (1940).

practitioner a wide discretion and trusting to his good sense."²⁵ This, I submit, raises too great a risk of abuse and mistake to warrant a change in the existing law. That a proposal entails risk of mistake is hardly a conclusive reason against it. But neither is it irrelevant. Under any euthanasia program the consequences of mistake, of course, are always fatal. As I shall endeavor to show, the incidence of mistake of one kind or another is likely to be quite appreciable. If this indeed be the case, unless the need for the authorized conduct is compelling enough to override it, I take it the risk of mistake is a conclusive reason against such authorization. I submit too, that the possible radiations from the proposed legislation, *e.g.*, involuntary euthanasia of idiots and imbeciles (the typical "mercy-killings" reported by the press) and the emergence of the legal precedent that there are lives not "worth living," give additional cause in pause.

I see the issue, then, as the need for voluntary euthanasia versus (1) the incidence of mistake and abuse; and (2) the danger that legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others.²⁶

The "freedom to choose a merciful death by euthanasia" may well be regarded, as does Professor Harry Kalven in a carefully measured review of another recent book urging a similar proposal,²⁷ as "a special area of civil liberties far removed from the familiar concerns with criminal procedures, race discrimination and freedom of speech and religion."²⁸ The civil liberties angle is definitely a part of Professor Williams' approach:

25. Williams p. 339.

26. Cf. G. K. Chesterton, *Euthanasia and Murder*, 8 Am. Rev. 486, 490, (1927).

27. See Fletcher, *op. cit.* 7 *supra*, note 8.

28. Kalven, *supra*, note 27, at 130. He suggests that the suggestion that to some extent this freedom may be violated as a result of the freedom of religion of the non-believer. For a consideration of the problems raised by organizations which claim to be "religious" but do not require their adherents to believe in a Supreme Being, see Washington Ethical Soc'y v. Columbia, 249 F.2d 1177 (1st Cir. 1957); Fellowship of Humanity v. University of Alabama, 315 F.2d 394 (Cal. App. 1957), 38 Colum. L. Rev. 417 (1958).

Undoubtedly the most extreme expression of this view is the bitter comment of Viscount Esher, upon concluding from the run of the speeches that he and his brethren would be overwhelmed in the House of Lords debate on the question of voluntary euthanasia, 1911 L.J. 351, 374-76 (1960). "The extension of [voluntary euthanasia] is a very serious matter. The extension of liberty of great importance, giving to the individual new rights to which, up till now, he has not had access. . . . What we propose this afternoon is in point of fact, a new freedom, and undoubtedly it will antagonize the ennobled forces of the official world. . . . I believe that posterity will look back on this retreat you are going to make this afternoon . . . as

If the law were to remove its ban on euthanasia, the effect would merely be to leave this subject to the individual conscience. This proposal would . . . be easy to defend, as restoring personal liberty in a field in which men differ on the question of conscience. . . .

On a question like this there is surely everything to be said for the liberty of the individual.²⁹

I am perfectly willing to accept civil liberties as the battlefield, but issues of "liberty" and "freedom" mean little until we begin to pin down *whose* "liberty" and "freedom" and for *what* need and at *what* price. This paper is concerned largely with such questions.

It is true also of journeys in the law that the place you reach depends on the direction you are taking. And so, where one comes out on a case depends on where one goes in.³⁰

So it is with the question at hand. Williams champions the "personal liberty" of the dying to die painlessly. I am more concerned about the life and liberty of those who would needlessly be killed in the process or who would irrationally choose to partake of the process. Williams' price on behalf of those who are in *fact* "hopeless incurables" and *in fact* of a fixed and rational desire to die is the sacrifice of (1) some few, who, though they know it not, because their physicians know it not, need not and should not die; (2) others, probably not so few, who, though they go through the motions of "volunteering," are casualties of strain, pain or narcotics to such an extent that they really know not what they do. My price on behalf of those who, despite appearances to the contrary, have some relatively normal and reasonably useful life left in them, or who are incapable of making the choice, is the lingering on for awhile of those who, if you will, *in fact* have no desire and no reason to linger on.

people look now on the burning of witches—as a barbarous survival of medieval ideas, an example of that high-minded cruelty from the entanglement of which it has taken mankind so many centuries to emerge. In that day we few, we five or six shall, I believe, be remembered.

At the end, the euthanasias avoided a vote by withdrawing the question, *id.* 388. See also *supra*, note 27, at 130. The House of Commons' euthanasia legislation was defeated by a 35-14 vote. 103 H. L. Deb. (5th ser.) 466, 506 (1936).

29. Williams, pp. 341, 346.

30. Frankfurter, J., dissenting in *United States v. Rabinowitz*, 339 U.S. 56, 69 (1950).

Williams has used an example as any may be taken from Glanville Williams' own text, *Criminal Law: The General Part* § 180 (1953). With a deep concern for the *formal* "freedom not to conform" as his starting point, Williams makes a strong policy argument for immunizing from criminal law sanctions those "peculiar people" who for sincere religious reasons fail to immunize mental aid to their sick children. One who takes the best and most humane as his starting point might well reach a somewhat different conclusion.

The naked suggestion that mercy-killing be made a good defense against a charge of criminal homicide appears to have no prospect of success in the foreseeable future. Only recently, the Royal Commission on Capital Punishment "reluctantly" concluded that such homicides could not feasibly be taken out of the category of murder, let alone completely immunized:

[Witnesses] thought it would be most dangerous to provide that 'mercy killings' should not be murder, because it would be impossible to define a category which could not be seriously abused. Such a definition could only be in terms of the motive of the offender, . . . which is notoriously difficult to establish and cannot, like intent, be inferred from a person's overt actions. Moreover it was agreed by almost all witnesses, including those who thought that there would be no real difficulty in discriminating between genuine and spurious suicide pacts, that, even if such a definition could be devised, it would in practice often prove extremely difficult to distinguish killings where the motive was merciful from those where it was not. How, for example, were the jury to decide whether a daughter had killed her invalid father from compassion, from a desire for material gain, from a natural wish to bring to an end a trying period of her life, or from a combination of motives?³⁵

While the appeal in simply taking "mercy-killings" off the books is dulled by the likelihood of abuse, the force of the idea is likewise substantially diminished by the encumbering protective features proposed by the American and English Societies. Thus, Lord Dawson, an eminent medical member of the House of Lords and one of the great leaders of the English medical profession, protested that the English Bill "would turn the sick room into a bureau," that he was revolted by "the very idea of the sick chamber being visited by officials and the patient, who is struggling with this dire malady, being treated as if it was a case of insanity."³⁶ Dr. A. Leslie Banks, then Principal Medical Officer of the Ministry of Health, reflected that the proposed machinery would "produce an atmosphere quite foreign to all accepted notions of dying in peace."³⁷ Dr. I. Phillips Frohman has similarly objected to the American Bill as one whose "whole procedure is so lengthy that it does not seem consonant either with the 'mercy' motive on which presumably it is based, or with the 'bearableness' of the pain."³⁸

The extensive procedural concern of the euthanasia bills have repelled many, but perhaps the best evidence of its psychological misconception is that it has distressed sympathizers of the move-

35. 103 *ILL. Deb.* (5th ser.) 494-95 (1946).

36. Banks, *Euthanasia*, 161 *Practitioner* 101, 104 (1948).

37. Frohman, *Pressing Problems in Forensic Medicine: A Physician's View*, 31 *N.Y.U.L. Rev.* 1215, 1222 (1956).

ment as well. The very year the English Society was organized and a proposed bill drafted, Dr. Harry Roberts observed:

We all realize the intensified horror attached to the death-penalty by its accompanying formalities—from the phraseology of the judge's sentence, and his black cap, to the weight-gauging visit of the hangman to the cell, and the correct attendance at the final scene of the supplanted chaplain, the doctor, and the prison governor. This is not irrelevant to the problem of legalized euthanasia . . .³⁹

After discussing the many procedural steps of the English Bill Dr. Roberts observed: "I can almost hear the cheerful announcement: 'please, ma'am, the euthanizer's come.'"⁴⁰

At a meeting of the Médico-Legal Society, Dr. Kenneth McFadyen, after reminding the group that "some time ago he stated from a public platform that he had practiced euthanasia for twenty years and he did not believe he was running risks because he had helped a hopeless sufferer out of this life," commented on the English Bill:

There was no comparison between being in a position to make a will and making a patient choose his own death at any stated moment. The patient had to discuss it—not once with his own doctor, but two, three, or even four times with strangers, which was no solace or comfort to people suffering intolerable pain.⁴¹

Nothing rouses Professor Williams' ire more than the fact that opponents of the euthanasia movement argue that euthanasia proposals offer either inadequate protection or overelaborate safeguards. Williams appears to meet this dilemma with the insinuation that because arguments are made in the antithesis *they must each be invalid, each be obstructionist, and each be made in bad faith*.⁴²

It just may be, however, that each alternative argument is quite valid, that the trouble lies with the euthanasiaists themselves in seeking a goal which is *inherently inconsistent*: a procedure for

38. Roberts, *op. cit.* *supra* note 31, at 14-15.

39. Eareney, *Voluntary Euthanasia*, 8 *México-Legal & Crim. Rev.* 91, 106 (1940) (discussion following the reading of Judge Eareney's paper).

40. Williams, p. 334.

41. The promoters of the bill hoped that they might be able to mollify the opposition by providing that the doctor would not be in any right in the room if the patient put in no safeguards—all they had merely said that a doctor could kill his patient whenever he thought it right—they would have been passionately opposed on this ground. So they put in the safeguards.

42. Did the opposition like these elaborate safeguards? On the contrary, they made this a matter of complaint. The safeguards would, it was said, bring too much formality into the sick-room, and destroy the relationship between doctor and patient. So the safeguards were wrong, but no one of the opposition speakers said that he would have voted for the bill without the safeguards.

death which *both* (1) provides ample safeguards against abuse and mistake; and (2) is "quick" and "easy" in operation. Professor Williams meets the problem with more than bitter comments about the tactics of the opposition. He makes a brave try to break through the dilemma:

[T]he reformers might be well advised, in their next proposal, to abandon all their cumbersome safeguards and to do as their opponents wish, giving the medical practitioner a wide discretion and trusting to his good sense.

[T]he essence of the bill would then be simple. It would provide that no medical practitioner should be guilty of an offense in respect of an act done intentionally to accelerate the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character. Under this formula it would be for the physician, if charged, to show that the patient was seriously ill, but for the prosecution to prove that the physician acted from some motive other than the humanitarian one allowed to him by law.⁴¹

41. *Id.* at 339-40. The desire to give doctors a free hand is expressed numerous times:

[T]here should be no formalities and . . . everything should be left to the discretion of the doctor (p. 340) . . . the bill would merely leave this question to the discretion and conscience of the individual medical practitioner. (p. 341). . . . It would be the purpose of the proposed legislation . . . to remove the complete fear of the law so that they can think only of the relief of their patients' suffering. . . . It would bring the whole subject within ordinary medical practice. (*Id.*)

Williams suggests that the pertinent provisions might be worded as follows (345):

1. For the avoidance of doubt, it is hereby declared that it shall be lawful for a physician whose patient is seriously ill—

to refrain from taking steps to prolong the patient's life by medical means;

—unless it is proved that . . . the omission was not made, in good faith for the purpose of saving the patient from severe pain in an illness believed to be of an incurable and fatal character.

2. It shall be lawful for a physician, after consultation with another physician, to accelerate by any lawful means the death of a patient who is seriously ill, unless it is proved that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character.

The completely unrestricted authorization to kill by omission may well be based on Williams' belief, at 326, that the existing law of mercy-killing by omission "to prolong life is probably lawful" since the physician is "excused" from the duty to use reasonable care to conserve his patient's life "if life has become a burden." And he adds—as if this settles the legal question—that "the morality of an omission in these circumstances is concealed even by the title."

Williams' *Id.*, as he seems to, *that once a doctor has undertaken treatment and the patient is entrusted safely to his care, it is wrong by the bedside of the patient whose life has "become a burden" and let him die, e.g., by not replacing the oxygen bottle, I submit that he is quite mistaken.*

The out-imits of criminal liability for inaction are hardly free from doubt. It seems fairly clear under existing law that the special and traditional relationship between the physician and his patient is not to act, particularly where the patient is helpless and completely dependent on the physician, and that the physician who withholds life-preserving medical means of the type described above commits criminal homicide by omission. In this regard, see 2 Burdick, *Crimes* § 466c (1946); Hall, *Principles of Criminal Law* 272-78 (1942); Kenny, *Outlines of Criminal Law* 14-15, 107-09 (1903); *Encyclopedia of Criminal Law* 313-32 (1937); 1 Russell, *Crimes* 449-66 (10th ed. 1950); Tamm, *Crimes and Criminals* 67 Yale L.J. 590, 599-600, 621-26, 630 n. 142 (1938); Kirchheimer, *Criminal Omissions*, 55 Harv. L. Rev. 615, 625-28 (1942); Wechsler and Michael, *supra* note 5 at 724-25.

Nor am I at all certain that the Catholics do "concede" this point. Williams' reference is to Sullivan, *op. cit. supra* note 3, at 64. But Sullivan concedes that the Catholic Church has not rejected the doctrine of omissions, e.g., whether to call in a very expensive specialist, whether to undergo a very painful or very drastic operation.

The Catholic approach raises nice questions and draws fine lines. E.g., how many limbs must be amputated before an operation is to be regarded as a non-obligatory extraordinary act as opposed to "ordinary" means, but it is not clear that the Catholic Church has ever explicitly distinguished between an indictment for a "mercy-killing" by omission, not even one which directly and immediately produces death.

This, of course, is not to say that no such negative "mercy-killing" have ever occurred. There is reason to think that not too infrequently this is the fate of the defective newborn infant. Williams, at 22, simply asserts that the Catholic Church is not "any more in a position to insist that a doctor alter birth" as upheld in Britain at any rate, by the House of Lords, and nurses, who, when an infant is born seriously malformed, do not "strive officiously to keep alive." Fletcher, at 207 n. 54, makes a similar and likewise undocumented observation that "it has always been a quite common practice of midwives and, in modern times doctors simply to fail to resuscitate monstrous babies at birth, and to let the same effect be made twenty years later by the doctor." The *Encyclopedia of Criminal Law* (1937) at 313-14. A noted obstetrician and gynecologist, Dr. Frederic Loomis, has told of occasions where expectant fathers have, in effect, asked him to destroy the child, if born abnormal. Loomis, *Consultation Room* 53 (1946). For an eloquent presentation of the problem raised by the defective infant see *id.* at 53-64.

It is difficult to discuss the consultation feature of Williams' proposal for adult "mercy-killing." The consultation feature is a very important fact, plus the fact that Williams' recurrent theme is to give the general practitioner a free hand indicates that he himself does not regard consultation as a significant feature of his plan. The attending physician need only consult another general practitioner and there is no requirement that there be any concurrence in his diagnosis. There is no requirement of a written consultation, and the consultation is not required to be a consultation with a specialist. Probably there need be consultation only as to diagnosis of the disease and from that point on the extent and mitigatory nature of the pain, and the firmness and rationality of the desire to die is to be judged solely by the attending physician. For the view that even under rather elaborate consultation requirements, in many thinly staffed communities the consultation feature of Williams' proposal is a "very serious practical flaw," see *Life and Death*, Time, March 13, 1950, p. 50. After reviewing eleven case histories of patients wrongly diagnosed as having advanced cancer, diagnoses that stood uncorrected over long periods of time and after several admissions at leading hospitals, Doctors Laaslo, Colmer, Silver and Standard conclude: [*Errors in Diagnosis and Management of Cancer*, 33 *Annals Int. Med.* 670 (1950)]:

[I]t became increasingly clear that the original error was one easily made, but that the continuation of that error was due to an acceptance of the original data without exploring their verity and completeness.

Evidently, the presumption is that the general practitioner is a sufficient buffer between the patient and the restless spouse or overwrought or overreaching relative, as well as a depository of enough general scientific know-how and enough information about current research developments and trends, to assure a minimum of error in diagnosis and anticipation of new measures of relief. Whether or not the general practitioner will accept the responsibility Williams would confer on him is itself a problem of major proportions.⁴²

42. In taking the Hippocratic Oath, the oldest code of professional ethics, the physician promises, of course, to "give no deadly medicine to any one if asked, nor suggest any such counsel." Many doctors have indicated that they would not sign such an oath if it were made more specific and direct. See, e.g., Frohman, *supra* note 37, at 124 ("I could never deliberately choose the time of another's dying. The preservation of human life is not only the primary but the all-encompassing general law underlying the code of the physician. . . . Do not ask life's guardian to be also its executioner."); *see also* Lard Haden-Guest, 169 H.L. Deb. (1911 ser.) 551, 586 (1900) ("I feel compelled to state that I would not sign the Hippocratic Oath as it stands, because I cannot make a decision"); Kennedy, *Euthanasia: To Be or Not To Be*, *Colliers*, May 20, 1939, pp. 15, 57, reprinted in *Colliers*, April 22, 1950, pp. 13, 50 ("Who is going to carry out the sentence of death? . . . and who is to be the executioner? . . . The profession of medicine is not a profession of killing. . . . In 1950 . . . killing trials (see the *Mohr* case, *supra* note 17, and the *Sonder, Poligh and Linasdorf* cases at notes 172-176, 183 *infra* and accompanying text) the General Assembly of the World Medical Association approved a resolution recommending to all national associations that they 'condemn the practice of euthanasia under any circumstances.' . . . New York Times, Oct. 18, 1950, at 22; *see also* *Medical Society of New York v. State of New York*, 1950 N.Y.2d 100, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 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the "voluntary" plan is supposed to be carried out "only if the victim is both sane and crazed by pain."⁴⁴

By hypothesis, voluntary euthanasia is not to be resorted to until narcotics have long since been administered and the patient has developed a tolerance to them. *When*, then, does the patient make the choice? While heavily drugged?⁴⁵ Or is narcotic relief to

44. Frohman, *Vexing Problems in Forensic Medicine: A Physician's View*, 31 N.Y.U.L. Rev. 1215, 1222 (1966).

45. The disturbing mental effects of morphine, "the classic opiate for the relief of severe pain," Schiffman and Gifford, *Psychiatric Aspects of the Management Of Pain In Cancer* p. 22 (Schiffman ed. 1966) and "until the most commonly used potent narcotic analgesic in treatment of cancer pain," Bouica, *The Management of Cancer Pain*, G.F., Nov. 1954, pp. 35, 39, have been described in considerable detail by Drs. Wolff, Hardy and Goodell in *Studies On Opiates: The Management of the Effect of Morphine, Codeine, and other Opiates in the Treatment of Pain* (1940). It is not surprising that attempts to generalize about the psychological effects of drugs for there is good reason to believe that the type of drug reaction is correlated with "differential personality dynamics, primarily in terms of the balance of mature, socially oriented controls over impulsive, egocentric emotionality," von Felsinger, *Psychiatric Aspects of the Management of Pain*, 137 A.M.A.J., 1113-1119 (1955); that for example, "the reactions of patients to drugs are likely to be those with pre-existing immaturity, anxiety and hostility" at 1116. See also Linlemann and Clark, *Modifications In Ego Structure and Personality Reactions Under the Influence of the Effects of Drugs*, 108 Am. J. Psychiatry 561 (1952). It would seem, however, that the severely ill persons would be likely to experience substantially more pronounced effects from the drugs than the healthy persons. Wolff, Hardy and Goodell, *supra*, because in that instance the "subjects" studied were the subjects of various degrees of pain by exposing portions of their skin surfaces to thermal radiation, but in the case of an illness due to a malignancy or suspected malignancy, we start with a situation where "all kinds of irrational attitudes come to the fore." *Psychological Aspects of Pain In Terminal Malignancies*, in Mann-46.

The increasing use of ACTH in cancer palliation, see notes 98-101, *infra* and accompanying text, presents further problems. Such therapy "frequently" leads to a "severe degree of disturbance in capacity for rational, sequential thought." Linlemann and Clark, *supra* at 566. Clark, *et al.*, *Psychomotor Observations On Mental Disturbances Occurring In Patients Under Therapy With Cortisone and ACTH*, 246 N. Eng. J. Med. 205, 215 (1952) describes six case histories of "major disturbances where 'delusions of persecutory type' were present, and in some cases hypomania and from apathy to panic; they included ill-defined states that might be described as bewilderment or turmoil." In a subsequent paper, the authors conclude, Clark, *et al.*, *Further Observations On Mental Disturbances Associated With Cortisone and ACTH Therapy*, 249 N. Eng. J. Med. 178, 182 (1953) that the disturbances "are more variable and unpredictable than any other feature," that, for example, mental disturbances may be separated by "intervals of relative lucidity," that "patients may have tolerated previous courses of ACTH or cortisone without complications and yet become psychotic during a subsequent course of treatment with comparable or even smaller doses."

For an extensive review of the many hypotheses, purporting to explain mental disturbances associated with ACTH and cortisone see Quartin, *et al.*, *Mental Disturbances Associated with ACTH and Cortisone: A Review of*

be withdrawn for the time of decision? But if heavy dosage no longer deadens pain, indeed, no longer makes it bearable, how overwhelming is it when whatever relief narcotics offer is taken away, too?

"If hypersensitivity to pain after analgesia has worn off is nearly always noted."⁴⁶ Moreover, "the mental side-effects of narcotics, unfortunately for anyone wishing to suspend them temporarily without unduly tormenting the patient, appear to outlast the analgesic effect" and "by many hours."⁴⁷ The situation is further complicated by the fact that "a person in terminal stages of cancer who had been given morphine steadily for a matter of weeks would certainly be dependent upon it physically and would probably be addicted to it and react with the addict's response."⁴⁸

The narcotics problem aside, Dr. Benjamin Miller, who probably has personally experienced more pain than any other commentator on the euthanasia scene,⁴⁹ observes:

Anyone who has been severely ill knows how distorted his judgment became during the worst moments of the illness. Pain and the toxic effect of disease, or the violent reaction to certain surgical procedures may change our capacity for rational and courageous thought.⁵⁰

If, say, a man in this plight were a criminal defendant and he were to decline the assistance of counsel would the courts hold that he had

Exploratory Hypotheses, 34 Med. 13 (1955). The authors emphasize the inadequacy of present knowledge of mental disturbances associated with this therapy, but believe "because of the clinical and experimental studies which suggest it," that "it is useful to assume" "cortisone and ACTH produce a [probably reversible] specific pattern of modified nervous system function which is invariably present when a gross mental disturbance occurs," *id.* at 4146. Goodman and Gilman, *The Pharmacological Basis of Therapeutics* 235 (2d ed. 1955). To the same effect is Severs and Pfeiffer, *A Study of the Analgesic, Subjective Depression, and Euphoria Produced by Morphine, Heroin, Diacetyl and Codeine In the Normal Human Subject*, 56 J. Pharm. & Exper. Therap. 166, 182, 187 (1936).

id. Sharpey-Schafer, *Adaptation At A Threat To Testamentary Capacity*, 35 N.C. R. 367, 370 (1935). The authors cite authorities cited herein. The authors conclude that "in the case of cortisone or ACTH therapy, the disturbances are complicated by the fact that 'a frequent pattern of recovery' from psychoses induced by such therapy is 'by the recurrence of lucid intervals of increasing frequency and duration, punctuated by relapses into psychotic behavior.'" Clark, *et al.*, *Further Observations On Mental Disturbances Associated With Cortisone and ACTH Therapy*, 249 N. Eng. J. Med. 178, 183, (1953).

Clark, *et al.*, *supra* at 205, 215. See also Linlemann, *op. cit. supra*, note 46 at 234, observe that while "different individuals require varying periods of time before the repeated administration of morphine results in tolerance, . . . as a rule, . . . after about two to three weeks of continued use of the same dose of alkaloid the usual depressant effects fail to appear." "Interruption phenomenally large doses may be taken." For a discussion of "withdrawal reactions," see Maurer and Vogel, *Narcotics and Narcotic Addiction*, 20-31 (1954).

49. See note 77 *infra* and accompanying text.
50. Miller, *If I Oppose Mercy Killings*, Woman's Home Companion, June 1950, pp. 38, 103.

"intelligently and understandingly waived the benefit of counsel?"⁵¹ Undoubtedly, some euthanasia candidates will have their lucid moments. How they are to be distinguished from fellow-sufferers who do not, or how these instances are to be distinguished from others when the patient is exercising an irrational judgment is not an easy matter. Particularly is this so under Williams' proposal, where no specially qualified persons, psychiatrically trained or otherwise, are to assist in the process.

Assuming, for purposes of argument, that the occasion when a euthanasia candidate possesses a sufficiently clear mind can be ascertained and that a request for euthanasia is then made, there remain other problems. The mind of the pain-racked may occasionally be clear, but is it not also likely to be uncertain and variable? This point was pressed hard by the great physician, Lord Horder, in the House of Lords debates:

During the morning depression [the patient] will be found to favour the application under this Bill, later in the day it will think quite differently, or will have forgotten all about it. The mental clarity with which noble Lords who present this Bill are able to think and to speak must not be thought to have any counterpart in the alternating moods and confused judgments of the sick man.⁵²

The concept of "voluntary" in voluntary euthanasia would have a great deal more substance to it if, as is the case with voluntary admission statutes for the mentally ill,⁵³ the patient retained the right to reverse the process within a specified number of days after he gives written notice of his desire to do so — but unfortunately this cannot be. The choice here, of course, is an irrevocable one.

The likelihood of confusion, distortion or vacillation would appear to be serious drawbacks to any voluntary plan. Moreover, Williams' proposal is particularly vulnerable in this regard, since, as he admits, by eliminating the fairly elaborate procedure of the American and English Societies' plans, he also eliminates a time period which would furnish substantial evidence of the patient's

51. Moore v. Michigan, 355 U.S. 155, 161 (1957).
52. 100 H. L. Deb. (3d Ser.) 1063 (1950). To the same effect is Lord Horder, *supra* note 51, at 1063. See also Gumpert, *A Fair Mercy*, 170 The Nation 80 (1950): "Even the inappetent, agonized patient in despair most of the time, may still get some joy from existence. His mood will change between longing for death and fear of death. Who would want to decide what should be done on such a fluctuating basis?"

For a recent layman's account of the self-pity and fluctuating desires for life and death of a seriously ill person, see the reflections of the famous sports broadcaster Ted Huc in *My Friends Wouldn't Let Me Die*, Look, Feb. 4, 1958, p. 64.
53. See Guttmacher and Weisbaden, *Psychiatry and the Law* 307 (1952).

settled intention to avail himself of euthanasia.⁵⁴ But if Williams does not always choose to slug it out, he can box neatly and parry gingerly:

[T]he problem can be exaggerated. Every law has to face difficulties in application, and these difficulties are not a conclusive argument against a law if it has a beneficial operation. The measure he proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible. The physician, conscious of the need to protect himself against malicious accusations, can devise his own safeguards appropriate to the circumstances; he would normally be well advised to get the patient's consent in writing, just as is now the practice before operations. Sometimes the patient's consent will be particularly clear because he will have expressed a desire for ultimate euthanasia while he is still clear-headed and before he comes to be racked by pain; if the expression of desire is never revoked, but rather is reaffirmed under the pain, there is the best possible proof of full consent. If, on the other hand, there is no such settled frame of mind, and if the physician chooses to administer euthanasia when the patient's mind is in a variable state, he will be walking in the margin of the law and may find himself unprotected.⁵⁵

If consent is given at a time when the patient's condition has so degenerated that he has become a fit candidate for euthanasia, when, if ever, will it be "clear and incontrovertible?" Is the suggested alternative of consent in advance a satisfactory solution? Can such a consent be deemed an informed one? Is this much different from holding a man to a prior statement of intent that if such and such an employment opportunity would present itself he would accept it, or if such and such a young woman were to come along he would marry her? Need one marshal authority for the proposition that many an "iffy" inclination is disregarded when the actual facts are at hand?⁵⁶

Professor Williams states that where a pre-pain desire for "ultimate euthanasia" is "reaffirmed" under pain, "there is the best

54. Williams, *supra* note 34, at 343-44.

55. *Id.* at 344.

56. Dr. James J. Walsh in *Life Is Sacred*, 94 The Forum, 333-34, recalls the following Aesop's fable:

It was a bitter-cold day in the wintertime, and an old man was gathering sticks for his fire. He had a bundle of sticks under his arm and was covered with ice; many of them were frozen and had to be pulled apart, and his discomfort was intense. Finally the poor old fellow became so thoroughly wrought up by his suffering that he called loudly upon death to come. To his surprise, Death came at once and asked what he wanted. Very hastily the old man replied, "Oh, nothing; nothing except to help me carry this bundle of sticks home so that I may make a fire."

possible proof of full consent." Perhaps. But what if it is alternately removed and reaffirmed under pain? What if it is neither affirmed or renounced? What if it is only renounced? Will a physician be free to go ahead on the ground that the prior desire was "rational," but the present desire "irrational"? Under Williams' plan, will not the physician frequently "be walking in the margin of the law" — just as he is now? Do we really accomplish much more under this proposal than to put the euthanasia principle on the books?

Even if the patient's choice could be said to be "clear and incontrovertible," do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or a cowardly act? Will not some feel an obligation to have themselves "eliminated" in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?

It would not be surprising for the gravely ill person to seek to inquire of those close to him whether he should avail himself of the legal alternative of euthanasia. Certainly, he is likely to wonder about their attitude in the matter. It is quite possible, is it not, that he will not exactly be gratified by any inclination on their part — however noble their motives may be in fact — that he resort to the new procedure? At this stage, the patient-family relationship may well be a good deal less than it ought to be:

Illness, pain and fear of death tend to activate the dependent longings [for the family unit]. Conflict can easily arise, since it may be very difficult for the individual to satisfy his need for these passive dependent needs and his previous concept of the necessity for a competitive, constructive individuality. Our culture provides few defenses for this type of stress beyond a suppression of the need. If the individual's defenses break down, he may feel angry toward himself and toward the members of his family.⁵⁷

And what of the relatives? If their views will not always influence the patient, will they not at least influence the attending physician? Will a physician assume the risks to his reputation, if not his pocketbook, by administering the *coup de grace* over the

57. Zarling, *supra* note 45, at 215.

objection — however irrational — of a close relative?⁵⁸ Do not the relatives, then, also have a "choice?" Is not the decision on their part to do nothing and say nothing itself a "choice?"⁵⁹ In many families there will be some, will there not, who will consider a stand against euthanasia the only proof of love, devotion and gratitude for past events? What of the stress and strife if close relatives differ — as they did in the famous *Sander* case⁶⁰ — over the desirability of euthanizing the patient?

At such a time, as the well-known *Faicht* case clearly demonstrates,⁶¹ members of the family are not likely to be in the best state of mind, either, to make this kind of decision. Financial stress and conscious or unconscious competition for the family's estate aside:

The chronic illness and persistent pain in terminal carcinoma may place strong and excessive stresses upon the family's emotional ties with the patient. The family members who have strong emotional attachment to start with are most likely to take the patient's fears, pains and fate personally. Panic often strikes them. Whatever guilt feelings they may have toward the patient emerge to plague them.

If the patient is maintained at home, many frustrations and physical demands may be imposed on the family by the advanced illness. There may develop extreme weakness, incontinence, and bad odors. The pressure of caring for the individual under these

58. The medical profession is apparently already quite sensitive about the "due consciousness" on the part of the public. See Caswell, *A Surgeon's Thoughts on Malpractice*, 30 Temple L.Q. 391 (1957) (symposium). There is a greater incidence of suit and claims against physicians alleging medical malpractice and against medical persons prosecuting these has led to "insecurity" on the part of many physicians and "the insecure physician is going to play it safe." Wachowski and Stronach, *The Radiologist and Professional Medical Liability*, 30 Temple L.Q. 398 (1957). Apparently, in some fields fear of claims and litigation has altered the psychological stage for undertreatment. *Id.* at 399.

59. Cf. the *Marshall* case, 1960-1961, 30 Temple L.Q. 399, 400 (1957).

60. See note 17, *supra*. See also the *Mahr* case; *supra* note 17, where two brothers testified against a third who had euthanized a fourth.

61. See note 17b, *supra*.

circumstances is likely to arouse a resentment and, in turn, guilt feelings on the part of those who have to do the nursing.⁶²

Nor should it be overlooked that while Professor Williams would remove the various procedural steps and the various personnel contemplated in the American and English bills and hank his all on the "good sense" of the general practitioner, no man is immune to the fear, anxieties and frustrations engendered by the apparently helpless, hopeless patient. Not even the general practitioner:

Working with a patient suffering from a malignancy causes special problems for the physician. First of all, the patient with a malignancy is most likely to engender anxiety concerning death, even in the doctor. And at the same time, this type of patient constitutes a serious threat or frustration to medical intuition. As a result, a doctor may react more emotionally and less objectively than in any other area of medical practice. . . . His deep concern may make him more pessimistic than is necessary. As a result of the feeling of frustration in his wish to help, the doctor may have moments of annoyance with the patient. He may even feel almost inclined to want to avoid this type of patient.⁶³

The only Anglo-American prosecution involving an alleged mercy-killing physician seems to be the case of Dr. Herman Sander. The state's testimony was to the effect that, as Sander had admitted on various occasions, he finally yielded to the persistent pleas of his patient's husband and pumped air into her veins "in a weak moment."⁶⁴ Sander's version was that he finally "snapped" under the strain of caring for the cancer victim,⁶⁵ bungled simple tasks,⁶⁶ and became "disseised" with the need to "do something" for her — if

62. Zarling, *supra* note 45 at 211-12.

63. *Id.* at 213-14. See also Dr. Benjamin Miller to the effect that cancer illness may emotionally exhaust the relatives and physician even more than the patient. Miller, *supra* note 50, at 101; and Stephen, *Murder from the Heart of Mothers*, 51 Q. Rev. 188 (1889), commenting on the disclosure by a doctor to his patient of the fact that he had been told by the relatives that the only person for whom the lady's death, if she had been allowed to die naturally, would have been in any degree painful was not the lady herself, but Dr. "Thwing".

64. N.Y. Times, Feb. 24, 1950, p. 1, col. 6.

65. "As I looked at her face and all of the thoughts of the past went through my mind, something snapped in me, and I felt impelled or possessed to do what I did. I don't know why I did it. I can't tell. It doesn't make sense." N.Y. Times, March 7, 1950, p. 1, col. 1.

66. "I didn't see a lightning, which is also rather a ridiculous thing, because ordinarily in a normal patient we put on a tourniquet to bring in the vein so that we can see it. Her veins were collapsed anyhow and I couldn't have been thinking this way. I ordinarily do at the time. Otherwise I wouldn't have acted this way." *Id.*

only to inject air into her already dead body.⁶⁷ Whichever side one believes — and the jury evidently believed Dr. Sander⁶⁸ — the case well demonstrates that at the moment of decision the tired practitioner's "good sense" may not be as good as it might be.

Putting aside the problem of whether the good sense of the general practitioner warrants dispensing with other personnel, there still remains the problems posed by any voluntary euthanasia program: the aforementioned considerable pressures on the patient and his family. Are these the kind of pressures we want to inflict on any person, let alone a very sick person? Are these the kind of pressures we want to impose on any family, let alone an emotionally-shattered family? And if so, why are they not also proper considerations for the crippled, the paralyzed, the quadruple amputee, the iron lung occupant and their families?

Might it not be said of the existing ban on euthanasia, as Professor Herbert Wechsler has said of the criminal law in another connection:

It also operates, and perhaps more significantly, at anterior stages in the patterns of conduct, the dark shadow of organized disapproval eliminating from the ambit of consideration alternatives that might otherwise present themselves in the final competition of choice.⁶⁹

C. The "Hopelessly Incurable" Patient and the Fictitious Doctor.

Professor Williams notes as "standard argument" the plea that "no sufferer from an apparently fatal illness should be deprived of his life because there is always the possibility that the diagnosis is wrong, or else that some remarkable cure will be discovered in time."⁷⁰ But he does not reach the issue until he has already dismissed it with this prefatory remark:

67. "I just the appearance of her face and the combination of all the thoughts of the past went through my mind, something snapped in me, and I felt impelled or possessed to do what I did. I don't know why I did it. I can't tell. It doesn't make sense." *Id.*

68. See note 172 *infra*, and accompanying text.

69. Wechsler, *The Failure of the Nuremberg Trial*, 62 *Yale L.J.* 11, 16 (1947). Cf. Carliano, *What Medicine Can Do for Law*, in *Law and Literature* (1931).

70. Williams, *supra* note 1, at 101. It is necessary, indeed, not only to deter the man who is a criminal at heart, who has felt the criminal impulse, who is on the brink of inflection, but also to deter others who in our existing social organization have never felt the criminal impulse and shrink from crime in horror. Most of us have such a scorn and loathing of robbery or forgery or the temptation to large it even in the range of choice; it is not a real alternative. There can be little doubt that some of this repugnance is due to the stigma that has been attached to these and like offenses, through the sanctions of the criminal law. If the immunity were withdrawn, the horror might be dimmed.

70. Williams, *supra* note 1, at 318.

It has been noticed before in this work that writers who object to a practice for theological reasons frequently try to support their condemnation on medical grounds. With euthanasia this is difficult, but the effort is made.⁷¹

Does not Williams, while he pleads that euthanasia not be theologically prejudged, at the same time invite the inference that non-theological objections to euthanasia are simply camouflage?

It is no doubt true that many theological opponents employ medical arguments as well, but it is also true that the doctor who has probably most forcefully advanced medical objections to euthanasia of the so-called incurables, Cornell University's world-renowned Foster Kennedy, a former president of the Euthanasia Society of America, *advocates* euthanasia in other areas where error in diagnosis and prospect of new relief or cures are much reduced, i.e., the "congenitally unfit."⁷² In large part for the same reasons, Great Britain's Dr. A. Leslie Ibbanks, then Principal Medical Officer of the Ministry of Health, maintained that a better case could be made for the destruction of congenital idiots and those in the final stages of dementia, particularly senile dementia, than could be made for the doing away of the pain-stricken incurable.⁷³

71. *Id.* at 317-18.
72. "What to do with the hopelessly unfit? I had thought at a younger time of my life that the legalizing of euthanasia—a soft gentle-sounding cure—was a thing to be encouraged; but as I pondered, and as my experience in medicine grew, I became more and more convinced that the legalizing of euthanasia for any person who has been found to be incurably ill, for however ill they be, many get well and help the world many years after. But I am in favor of euthanasia for those hopeless ones who should never have been born—Nature's mistakes. In this category it is, in my opinion, impossible to be mistaken in either diagnosis or prognosis. . . . I am in favor of the strictest and most careful control of the Congenital Deformed." *Am. J. Psychiatry*, 13, 14 (1923).
73. "We doctors do not always know when a disease in a previously healthy person has become entirely incurable. But there are thousands and tens of thousands of the congenitally unfit, about whom no diagnostic error would be possible. . . . with nature's mistakes, . . . there can be, after five years . . . of continued diagnosis, not any hope of betterment." Kennedy, *Euthanasia: To Flourish or to Withers*, May 20, 1939, pp. 15, 58; reprinted in *Colliers*, April 22, 1950, pp. 13, 51.

At the February, 1939, meeting of the Society of Medical Jurisprudence, Charles E. Nixdorf, treasurer and board chairman of the Euthanasia Society of America stated that the case of a 19-year-old girl in Bellevue, with a broken back and paralyzed legs, who "prayed for death every night," was a "typical case of the Euthanasia Society to carry on the fight." ("Dr. [Foster] Kennedy [then President of the Euthanasia Society] in conversation, said later he did not think that was a particularly good example. He said he had known many such cases where the patients 'got around' and only recently he had 'danced with one.'" *N.Y. Times*, Feb. 14, 1939, p. 2, col. 6.

73. Ibbanks' position that incurability is capable of precise and final definition, and indeed if each case is carefully considered there would be conflict of medical opinion in practically every instance." *Id.* at 106.

Surely, such opponents of voluntary euthanasia cannot be accused of wrapping theological objections in medical dressing!

Until the euthanasia societies of England and America had been organized and a party decision reached, shall we say, to advocate euthanasia only for incurables on their request, Dr. Abraham L. Wolbarst, one of the most ardent supporters of the movement, was less troubled about putting away "insane or defective people [who] have suffered mental incapacity and tortures of the mind for many years" than he was about the "incurables."⁷⁴ He recognized the "difficulty involved in the decision as to incurability" as one of the "doubtful aspects of euthanasia."

Doctors are only human beings, with few if any supermen among them. They make honest mistakes, like other men, because of the limitations of the human mind.⁷⁵

He noted further that "it goes without saying that, in recently developed cases with a possibility of cure, euthanasia should not even be considered," that "the law might establish a limit of, say, ten years in which there is a chance of the patient's recovery."⁷⁶

Dr. Benjamin Miller is another who is unlikely to harbor an ulterior theological motive. His interest is more personal. He himself was left to die the death of a "hopeless" tuberculosis victim only to discover that he was suffering from a rare malady which affects the lungs in much the same manner but seldom kills. Five years and sixteen hospitalizations later, Dr. Miller dramatized his point by recalling the last diagnostic clinic of the brilliant Richard Cabot, on the occasion of his official retirement:

He was given the case records [complete medical histories and results of careful examinations] of two patients and asked to diagnose their illnesses. . . . The patients had died and only the hospital pathologist knew the exact diagnosis beyond doubt, for he had seen the descriptions of the postmortem findings. Dr. Cabot, usually very accurate in his diagnosis, that day missed both.

The chief pathologist who had selected the cases was a wise person. He had purposely chosen two of the most deceptive to remind the medical students and young physicians that even at the end of a long and rich experience one of the greatest diagnosticians of our time was still not infallible.⁷⁷

74. Wolbarst, *Legalize Euthanasia*, 94 *The Forum* 330, 332 (1935). *But see* Wolbarst, *The Doctor Looks at Euthanasia*, 149 *Medical Record*, 354 (1939).

75. Wolbarst, *Legalize Euthanasia*, 94 *The Forum* 330, 331 (1935).

76. *Id.* at 332.

77. Miller, *supra* note 50, at 39.

Richard Cabot was the John W. Davis, the John Lord O'Hrian, of his profession. When one reads the account of his last clinic, one cannot help but think of how fallible the average general practitioner must be, how fallible the young doctor just starting practice must be—and this, of course, is all that some small communities have in the way of medical care—how fallible the worst practitioner, young or old, must be. If the range of skill and judgment among licensed physicians approaches the wide gap between the very best and the very worst members of the bar—and I have no reason to think it does not—then the minimally competent physician is hardly the man to be given the responsibility for ending another's life.⁷⁶ Yet, under Williams' proposal at least, the marginal physician, as well as his more distinguished brethren, would have legal authorization to make just such decisions. Under Williams' proposal, euthanizing a patient or two would all be part of the routine day's work.⁷⁷

Perhaps it is not amiss to add as a final note, that no less a euthanasiaist than Dr. C. Killick Millard⁷⁸ had such little faith in the average general practitioner that as regards the *merre administration* of the *comp de grace*, he observed:

In order to prevent any likelihood of bungling, it would be very necessary that only medical practitioners who had been specially licensed to euthanize (after acquiring special knowledge and skill) should be allowed to administer euthanasia. Quite possibly, the work would largely be left in the hands of the official euthanasists, who would have to be appointed specially for each area.⁷⁹

True, the percentage of correct diagnosis is particularly high in cancer.⁸⁰ The short answer, however, is that euthanasiaists most emphatically do not propose to restrict mercy-killing to cancer cases. Dr. Millard has maintained that "there are very many diseases be-

76. As to how bad the bad physician can be, see generally, even with a grain of salt, J. Helli, *Modern Trials* 48, 327-353 (1954). See also Regan, *Doctors and Patients and the Law* 17-40 (3d ed. 1956).

77. See *supra* note 76, at 39-40.

78. As Williams points out, p. 330, Dr. Millard introduced the topic of euthanasia into public debate in 1932 when he advocated that mercy-killing should be legalized in his presidential address to the Society of Medical Officers of Health. In moving the second reading of the voluntary euthanasia bill, Lord Foranomy stated that the movement in favour of making a bill "was originated" with Dr. Millard. 103 H.L. Deb. 466-67 (1936).

79. Millard, *The Case for Euthanasia*, 136 *Fortnightly Review* 701, 717 (1931). Under his proposed safeguards (two independent doctors, followed by a "medical referee"), Dr. Millard viewed error in diagnosis as a non-terminable, remote possibility.

80. Euthanasia opponents readily admit this. See *e.g.*, Miller, *supra* note 58, at 38.

sides cancer which tend to kill 'by inches', and where death, when it does at last come to the rescue, is brought about by pain and exhaustion.⁸¹ Furthermore, even if mercy-killings were to be limited to cancer, however relatively accurate the diagnosis in these cases, here, too, "incurability of a disease is never more than an estimate based upon experience, and how fallacious experience may be in medicine only those who have had a great deal of experience fully realize."⁸²

Dr. Daniel Laszlo, Chief of Division of Neoplastic Diseases, Montefiore Hospital, New York City, and three other physicians have observed:

The mass crowding of a group of patients labeled 'terminal' in institutions designated for that kind of care carries a grave danger. The experience gathered from this group makes it seem reasonable to conclude that a fresh evaluation of any large group in mental institutions, in institutions for chronic care, or in homes for the incurably sick, would unearth a rewarding number of salvageable patients who can be returned to their normal place in society. . . . For purposes of this study we were especially interested in those with a diagnosis of advanced cancer. In a number of these patients, major errors in diagnosis or management were encountered.⁸³

The authors then discuss in considerable detail the case histories of eleven patients admitted or transferred to Montefiore Hospital alone with the diagnosis of "advanced cancer in its terminal stage," none of whom had cancer at all. In three cases the organ suspected to be the primary site of malignancy was unaffected; in the other eight cases it was the site of some nonmalignant disease. The impact of these findings may be gleaned from a subsequent comment by Doctors Laszlo and Spencer: "Such cases [of mistaken diagnosis of advanced cancer] are encountered even in large medical centers and probably many more could be found in areas poorly provided with medical facilities."⁸⁴

Only recently, Dr. R. Ger, citing case histories of false cancer

83. Millard, *supra* note 81, at 702.

84. Frohman, *Facing Problems in Forensic Medicine: A Physician's View*, 31 N.Y.U. Rev. 1215, 1216 (1956). Dr. Frohman added: "The fact that the patient is not subject to experimental and research scientists, but an ill patient is not subject to experimental control, nor are his reactions always predictable. A good physician employs his scientific tools whenever they are useful, but many are the times when intuition, chance, and faith are his most successful techniques." 85. *Law, Ethics, and Medicine* 116 (1956).

86. Laszlo and Spencer, *Medical Problems in The Management Of Cancer*, 37 *Med. Clin. N.A.* 869, 873 (1953).

diagnoses to buttress his point, had occasion to warn his colleagues:

Students are often told, and one is exhorted repeatedly in textbooks to do so, to regard signs and symptoms appearing over the age of 40 years as due to carcinoma [malignant epithelial tumor] until proved otherwise. While it is true that carcinoma should take first place on grounds of commonness, it must not be forgotten that there are other conditions which may mimic carcinoma clinically, radiologically and at operation, and which are essentially benign. There is danger, moreover, when presented with a case simulating carcinoma to assume it to be carcinoma without proving or disproving the diagnosis. This may give rise to unnecessary fatalities by either denying treatment because of a hopeless prognosis or carrying out unnecessary procedures.⁸⁷

Even more recently, Doctors De Vet and Walder scored the "extremely dangerous" tendency on the part of general practitioners and specialists alike "when a neoplasm becomes manifest in a patient previously operated on for a malignant tumour . . . to presume that the new growth is a metastasis [a transfer of the malignant disease]."⁸⁸ Their studies demonstrated that it is "by no means a rare occurrence" for patients to develop "another, benign tumour after having been operated upon for a malignant one."⁸⁹ De Vet and Walder also stress the "remarkable similarity" in symptoms, including "violent pain" in both cases, between metastases and benign processes of the spinal column and the spinal cord.⁹⁰

Faulty diagnosis is only one ground for error. Even if the diagnosis is correct, a second ground for error lies in the possibility that some measure of relief, if not a full cure, may come to the fore within the life expectancy of the patient. Since Glauvill Williams does not deny this objection to euthanasia worth more than a passing

87. *See, Diagnosis and Misdiagnosis of Carcinoma*, 28 So. Afr. Med. J. 670 (1954).

88. De Vet and Walder, *Pseudo-Metastases*, 7 Acta Chirurgica Neerlandicum 78 (1955).

89. *Id.* at 81.

90. *Id.* at 82. Consider also the following: At the 1951 annual meeting of the American Cancer Society, devoted to cytological diagnosis of cancer, Dr. Henry Cox (Memphis, Tenn.) said: "The problem of cancer diagnosis is a very real one." *Proceedings, Symposium on Esophageal Cancer*, 106 (Oct. 23-24, 1951).

The problem of false positive diagnosis has always been a difficult one. About 5 per cent of the 541 non-cancer patients in whom cancer secretions have been studied in the past had false positive diagnosis made, and in our experience, gastritis has been a common cause of false positive diagnosis.

At the same meeting, Dr. William A. Cooper told of "fifteen misses" in X-ray diagnosis of cancer out of one hundred cases (*id.* at 102).

Four of the twenty-five cases of cancer were said to have benign lesions, while eleven of the seventy-five benign lesions were said to have cancer.

ing reference,⁹¹ it is necessary to turn elsewhere to ascertain how it has been met.

One answer is:

It must be little comfort to a man slowly coming apart from multiple sclerosis to think that, fifteen years from now, death might not be his only hope.⁹²

To state the problem this way is of course, to avoid it entirely. How do we know that fifteen days or fifteen hours from now, "death might not be [the incurable's] only hope?"

A second answer is:

[I]n cure for cancer which might be found 'tomorrow' would be of any value to a man or woman 'so far advanced in cancerous toxemia as to be an applicant for euthanasia'.⁹³

As I shall endeavor to show, this approach is a good deal easier to formulate than it is to apply. For one thing, it presumes that we know today *what* cures will be found tomorrow. For another, it overlooks that if such cures can be said to exist, the patient is likely to be *so far* advanced in cancerous toxemia as to be no longer capable of understanding the step he is taking and hence *beyond* the stage when euthanasia ought to be administered.⁹⁴

A generation ago, Dr. Haven Emerson, then President of the American Public Health Association, made the point that "no one can say today what will be incurable tomorrow. No one can predict what disease will be fatal or permanently incurable until medicine becomes stationary and sterile." Dr. Emerson went so far as to say that "to be at all accurate we must drop altogether the term 'in-

91. See Williams, p. 318.

92. *Pro & Con: Shall We Legalize "Mercy Killing"?*, Readers Digest, Nov. 1938, pp. 94, 96.

93. James, *Euthanasia—Right or Wrong?*, Survey Graphic, May, 1948, pp. 241, 243; Volbarsht, *The Doctor Looks at Euthanasia*, 149 Medical Record, 354, 355 (1939).

94. Thus, Doctor Millard, in his leading article, *supra* note 81, at 710, states:

A patient who is too ill to understand the significance of the step he is taking has got beyond the stage when euthanasia ought to be administered. In any case his sufferings are probably nearly over.

Under the full and informed consent of the patient, the consent of the patient Glauvill Williams similarly observes (pp. 340-341). It is true that some doctors are now accustomed to give fatal doses without consulting the patient. I take it to be clear that no legislative sanction can be accorded to this practice, in so far as the course of the disease is deliberately anticipated. The essence of the measures proposed by the two societies is that euthanasia should be voluntarily accepted by the patient. The measure proposed is designed to meet the situation where the patient's consent to euthanasia is clear and incontrovertible.

curables" and substitute for it some such term as "chronic illness."⁹² That was a generation ago. Dr. Emerson did not have to go back more than a decade to document his contention. Before Banting and Best's insulin discovery, many a diabetic had been doomed. Before the Whipple-McMurrill liver treatment made it a relatively minor malady, many a pernicious anemia sufferer had been branded "hopeless." Before the uses of sulfanilamide were disclosed, a patient with widespread streptococcal blood poisoning was a doomed man.⁹³

Today, we may take even that most resolute disease, cancer, and we need look back no further than the last decade of research in this field to document the same contention.⁹⁴

Three years ago, Dr. William D. McCarthy presented the results to date, of an effort begun in 1950 to open a new approach in cancer palliation,⁹⁵ a report whose findings of "remarkable improvement" in nearly a third of the cases invoked strong editorial comment in the *New England Journal of Medicine*.⁹⁶ At the time of Dr. McCarthy's report, 100 "hopeless" patients with a wide variety of neoplasms had been treated with a combination of nitrogen mustard and ACTH or cortisone. "All patients in the series were in advanced or terminal phases of disease, and were accepted for treatment only after the disease was determined to be progressive after adequate surgery or radiation therapy."⁹⁷ Dr. McCarthy summarizes the results:

In several of these cases there was associated tumor regression or arrest, with definite prolongation of life in increased comfort. This group constituted 15 per cent of the series. Reserved for this classification as excellent response were 16 additional patients (16 per cent) whose subjective and objective remissions were striking, often accompanied with tumor regression or arrest, and whose improvement persisted for six months or longer. These patients represent the true temporary remissions of the series. They are, however, temporary remissions and not

⁹² Emerson, *supra* note 5, at 39.
⁹³ *Id.*, *supra* note 50, at 39.
⁹⁴ *Id.*, *supra* note 50, at 39.

⁹⁵ This is not to say that progress in the treatment of cancer cases has been limited to the last decade. Over twenty years ago, Lord Howard of Effingham, *supra* note 103, H.L. Deb. 466, 492 (1936), opposing the euthanasia bill in the House of Lords declared, observed "It is common knowledge that the essential causative factors of cancer still elude us, there are patients to-day suffering from this disease, not only living but free from pain, who would not have been living ten years ago, and this as the result of advances made in treatment."

⁹⁶ McCarthy, *The Palliation and Remission of Cancer*, 252 N. Eng. J. Med. 467 (1955).

⁹⁷ *Treatment of Advanced Cancer*, 252 N. Eng. J. Med. 502 (1955).

¹⁰⁰ McCarthy, *supra* note 98 at 448.

permanent remissions or so called 'cures.' Nevertheless, as a group originally considered hopeless, each has been afforded longer life, acceptable health and freedom from pain. Fortunately, prolongation of life appeared to occur only in patients who received good palliation. . . .
 Unusual temporary remissions for intervals as long as three years were obtained. . . .⁹⁸

Needless to say, a number of those who received substantial benefits from this particular therapy were suffering from great pain and appeared to be leading candidates for voluntary euthanasia. In 1950, the year the new combination therapy investigation was initiated, a swift death appeared to be their only hope. Instead they resumed full and useful lives for a considerable period of time.⁹⁹

Since February, 1951, in a new effort to inhibit certain cancer growth,¹⁰⁰ a number of advanced cancer patients at the Memorial Center for Cancer and Allied Disease have had their adrenal glands removed.¹⁰¹ Of a total of ten patients with cancer of the prostate adenocarcinoma at the time of the 1952 report, three died in the immediate postoperative period of various causes, leaving seven

¹⁰⁰ *Id.* at 470, 475. Some of the results were little short of spectacular. See e.g., Case 1, *id.* at 470, the case of a woman whose reticulum-cell sarcoma "was considered too disseminated for radiation therapy" who responded so well to therapy that she returned to employment as a nurse for three years; Case 3, *id.*, that of a man taken to the hospital with a diagnosis of "a metastatic lymphosarcoma of the prostate gland" who had received X-ray therapy and "was rapidly increasing rapidly in size, who returned to his occupation and but for a short interval when he underwent a second course of therapy 'continued working up to the time of his death. . . . eighteen months after the 1st course of combination therapy'; Case 11, *id.* at 472-73, that of a "stomach cancer victim" in a terminal condition, unable to retain food or fluids, who after three months of treatment "regained weight and returned to his normal weight, returned to her . . . and enjoyed excellent health for a full year."

On the other hand, some 40 per cent of the group were considered failures (those who died within a month and those who survived longer but received little benefit); 29 per cent were classed as fair in response (moderate but brief palliation). *Id.* at 470.

¹⁰¹ See e.g., Case 1, *supra* note 100, and *Pain In Cancer*, 9 *Unio Internat. Canc.* 367 (1953), a report of the promising experimental chemotherapeutic measures (α-hydroxy, glycine and sodium thiosulfate) of Dr. Emanuel Revici and the staff of the Institute of Applied Biology. A number of patients whose cancers "had advanced beyond the point where any help was to be anticipated from X-ray therapy" returned to their normal occupations after the onset of treatment and remained on the job for several years.

¹⁰³ Drs. Huggins and Scott had reported the first total bilateral adrenalectomy in patients with prostatic carcinoma in 1936. The cortisone was not then known and the adrenal insufficiency was not practical and temporarily obliterated at that time that the operation was not practical and temporarily obliterated at that time. See Huggins and Scott, *Bilateral Adrenalectomy In Prostatic Cancer*, *Clinical Frontier and Urinary Excretion of 17 Ketosteroids and Estrogen*, 122 *Annals of Surgery* 1031 (1945).

¹⁰⁰ West, et al., *The Effect of Bilateral Adrenalectomy Upon Neoplastic Tissue in Man*, 5 *Cancer* 1009 (1952).

effective cases for evaluation:

The most striking beneficial response to adrenalectomy was relief of pain. Three of the patients were confined to bed with pain prior to surgery and were taking narcotics frequently. . . . All three had striking relief of pain postoperatively and became ambulatory. One (J.W.) was in a stuporous condition preoperatively, confined to bed, and unable to feed himself. Following adrenalectomy his general condition improved remarkably. He became ambulatory and was able to return home to live a relatively normal life. This improvement has been maintained until the present, 218 days after surgery. . . .

Summarizing the prostatic cancer cases, all seven effective cases had striking subjective improvement. Only two cases showed objective improvement. Improvement was temporary in all cases.¹⁰⁵

From all indications "J.W." was a most attractive target for the euthanasists. He was suffering from "severe pain requiring frequent injections of narcotics for relief . . . was extremely lethargic and relatively unresponsive . . . had to be fed by the nursing staff."¹⁰⁶ If he, to use Dr. Wollast's words, was not "so far advanced in cancerous toxemia as to be an applicant for euthanasia," when will anybody be? I am not at all sure that at this point J.W. was still *capable* of consenting to his death. If he were, he certainly had reached the very brink. As it turned out, however, to have put J.W. out of his misery at the time would have been to deprive him of over seven months of a "relatively normal life."¹⁰⁷ Adequate quantities of cortisone and other active corticoids had just become available. The postoperative problem of adrenal insufficiency had just been solved.

Breast cancer, the most common cancer in woman,¹⁰⁸ has also yielded substantially to adrenalectomy. A recent five-year evaluation of 52 consecutive patients with metastatic mammary cancer who underwent adrenalectomy disclosed that significant objective

105. *Id.* at 1012-13. Dr. M. P. Reiser of the University of Minnesota Medical School and his colleagues have planted radon-filled seeds of gold into the prostate area in an effort to save patients with "inoperable" cancer of the prostate gland. As a result, thirteen of twenty-five patients have gone of radium 3 years, 14 days, lived from three to seven years. Reiser, in the *Annals of the New York Academy of Sciences*, 1958, 13, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

106. West, *supra* note 104 at 1010.

107. An addendum to the report discloses that J.W.'s post-operative "subjective improvement" lasted 226 days and that he survived for 264 days. *Id.* at 1016-17. What pain J.W. suffered in his last days is not revealed, but in general discussion the authors state that ". . . [I]n the majority of the patient later died of 'relatively normal life' . . .".

108. American Cancer Society, 1958 *Cancer Facts and Figures* 47.

remissions of varying lengths of time occurred in 20 patients.¹⁰⁹ Prolonged survival—from three years to 68 months—occurred in seven of these patients, all of whom had been suffering from advanced stages of the disease, had failed to respond to various other types of therapy and were incapacitated. After treatment, "all of them were able to resume their normal physical activities."¹¹⁰ One of the seven had had such extensive metastases that she "appeared to be moribund," but she survived, with great regression of the neoplasm, more than five years after adrenalectomy.¹¹¹

The pituitary gland, as well as the adrenal glands, has had an increasing apparent role in the control of breast cancer. Since 1951, the availability of ACTH and cortisone has allowed an intensive investigation of the effects of hypophysectomy, i.e., surgical removal of the pituitary body. The results have been most gratifying. A recent report, for example, discloses that of twenty-eight patients with advanced breast cancer who underwent total hypophysectomy, "eighteen . . . have demonstrated striking objective clinical regressions" up to twenty months while an additional four who showed no objective evidence of regression experienced "striking relief of pain."¹¹²

The dynamic state of current cancer research would appear to be amply demonstrated by the indication, already that in the treatment of advanced breast cancer, adrenalectomy, itself still in the infant stages, may yield to hypophysectomy.¹¹³

109. Dao and Huggins, *Metastatic Cancer of the Breast Treated by Adrenalectomy*, 165 *A.M.A.J.* 1793 (1957). Furthermore, an additional nine patients who underwent no demonstrable regression experienced marked objective improvement in relief of bone pain, disappearance of respiratory symptoms and return of a sense of well-being. An earlier report on adrenalectomy disclosed that of five "effective" breast carcinoma cases, a sixth, having died of other causes a short time after adrenalectomy, "had had severe pain preoperatively, and all had either partial or complete relief of pain following adrenalectomy." West, *supra* note 104, at 1014.

110. *Id.* at 1796.

111. *Ibid.*

112. Kennedy, French and Peyton, *Hypophysectomy in Advanced Breast Cancer*, 35 *N. Eng. J. Med.*, 1165, 1171 (1956). See also Kennedy, *The Pituitary Gland: Its Role in Cancer Therapy in Advanced Breast Cancer*, 69 *Radiology* 330, 333-34 (1957).

For earlier reports, see Luit and Olivecrona, *Hypophysectomy in Man: Experiences in Metastatic Cancer of the Breast*, 8 *Cancer* 261 (1955). 113. Of 37 patients showed subjective or objective improvement from 3 to 27 months. A. M. J. 1793 (1957). Hypophysectomy in Treatment of Advanced Breast Cancer, 165 *A.M.A.J.* 1793 (1957). Over half of 41 patients who could be evaluated underwent objective remissions. 113. In view of the favorable responses after hypophysectomy, the constant adrenal atrophy and the ease in managing the patient, it appears that hypophysectomy is to be preferred over adrenalectomy in the treatment of advanced breast cancer. Kennedy, French and Peyton, *supra* note 112, at 1171.

or several must die that he or others may live. "Modern legal systems . . . do not require divine knowledge of human beings."¹¹⁸

Reasonable mistakes, then, may be tolerated if as in the above circumstances and as in the case of the surgical operation, these mistakes are the inevitable by-products of efforts to save one or more human lives.¹¹⁹

The need the euthanasia advances, however, is a good deal less compelling. It is only to ease pain.

Let us next examine the quantitative need for euthanasia:

No figures are available, so far as I can determine, as to the number of say, cancer victims, who undergo intolerable or overwhelming pain. But an appreciable number do suffer such pain, I have no doubt. But that anything approaching this number whatever it is, need suffer such pain, I have—viewing the many sundry

113. Hall, *General Principles of Criminal Law*, 399 (1947). Cardozo, on the other hand, seems to say that absent such certainty it is wrong for those who are not certain to take the life of another. *People v. Jackson*, 130 N.Y. 210, 213 (1905). Cardozo's view as one which "seems to deny that we can ever reach enough certainty as to our factual beliefs to be morally justified in the action we take." *Id.* at 70-71.

Some time after this paper was in galley, Section 3.02 of the Model Penal Code (tentative draft) was published. It reads: "The intentional killing of a human being is a crime, unless the killing has otherwise been justified." "Reckless" killings shall be deemed justifiable so long as the actor was not "reckless or negligent in bringing about the situation requiring a choice of evils or in appraising the necessity for his conduct." The section only applies to a situation where "the evil sought to be avoided by such conduct is greater than that sought to be prevented by the law." *Reckless killing* is defined as follows: "The defendant acted with recklessness when he acted to save himself at the expense of another, as by setting a raft when men are shipwrecked." Comment to Section 3.02, *supra* at 8. For "in all ordinary circumstances lives being must be assumed . . . to be of equal value, equally deserving the protection of the law." *Ibid.*

See also Calin, *The Moral Dilemma* (1955). Although he takes the position that the physician should not take the life of a patient, Calin's view of the doctor's view as one which "seems to deny that we can ever reach enough certainty as to our factual beliefs to be morally justified in the action we take." *Id.* at 70-71.

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It is often the wisest thing that a man can do to expose his life to great hazard. It is often the greatest service that can be tendered to him to do what may very probably cause his death. He may labor under a cruel and wasting malady which is certain to shorten his life, and which renders his existence a torment to himself and to his loved ones. Suppose that under these circumstances he, unheeded, gives his life and intelligent consent to take the risk of an operation which in a large proportion of cases has proved fatal, but which is the only method by which his disease can possibly be cured, and which, if it succeeds, will restore him to health and vigor. Suppose that the physician, who should perform the operation thoughtfully, by performing it he might cause death, not intending to cause death, but knowing himself to be likely to cause it.

palliative measures now available¹²⁰—considerable doubt. The whole field of severe pain and its management in the terminal stage of cancer is, according to an eminent physician, "a subject neglected far too much by the medical profession."¹²¹ Other well-qualified commentators have recently noted the "oblivious lack of interest in the literature about the problem of cancer pain"¹²² and have scored "the deplorable attitude of defeatism and therapeutic inactivity found in some quarters."¹²³

The picture of the advanced cancer victim beyond the relief of morphine and like drugs is a poignant one, but apparently no small

120. The management of intractable pain in cancer may be grouped under two main categories: (1) measures which check, decrease or eliminate the growth of the cancer; and (2) treatment, palliative operations for cancer and the use of drugs. In the first category are: (a) operations for cancer no longer curable; radiation, roentgen and X-ray therapy; administration of endocrine substances, steroids, nitrogen mustards, and radioactive iodine and iron. See text, at notes 98-113 *supra*. In the second category are non-narcotic analgesics such as cobra venom, hypodermics and sedatives; narcotic analgesics, such as morphine, codeine, and heroin; and (3) the use of chemical and surgical means to relieve pain, including the technique of choice in the management of cancer pain of the head and neck, spinalhalic tractotomy and chordotomy, for relief of pain at or below the nipple line; and pre-frontal lobotomy.

The various measures sketched above are discussed at considerable length in the following: *The Management of Cancer Pain* (G. P. Nov. 1954, p. 35, 1955); *Textbook of the Management of Cancer Pain* (G. P. Nov. 1954, p. 35, and more extensively by Doctors Schiffin and Gross (*Systematic Analgesics*), Sadove and Balogot (*Nerve Blocks*), *For Pain In Malignancy*), Sugar (*Neurosurgical Aspects of Pain Management*), Taylor and Schiffin (*Humoral and Chemical Palliation of Malignancy*), Schwartz (*Surgical Procedures for the Relief of Pain in Malignant Disease*), and *Relief of Pain in Cancer* (Schiffin ed. 1956).

Relief of pain by nerve blocking "has a great deal more to offer than prolonged narcotic therapy. Effective blocks produce adequate relief of pain and enable these patients to receive more intensive radiation therapy and other forms of medical treatment." *Textbook of the Management of Cancer Pain*, *supra* at 27. Backus, *supra* at 27. Bonica, *supra* at 43. "A recent analysis of cases reported in the literature revealed that of the many patients treated by alcohol nerve blocking, 63 per cent obtained complete relief, 23.5 per cent obtained partial relief, and only 13.5 per cent received no benefit from the block." Bonica, *supra* at 43.

It is the most useful and most effective neurosurgical operation for the relief of cancer pain. When skillfully carried out in properly selected patients, it produces complete relief in about 65 per cent of the patients, partial relief in another 25 per cent, and no relief in approximately 10 per cent. Bonica and Backus, *supra* at 25.

Pre-frontal lobotomy is a surgical procedure which many regard as a last resort. It is a surgical procedure which may cause serious and lasting changes in the patient's personality, frequently impairing judgment and causing apathy; the mental changes produced by unilateral lobotomy are much less marked, but pain is likely to recur if the patient survives more than several months. See Sugar, *supra*, at 101-104; Bonica, *supra* at 41-42.

121. See Schwartz, *supra* at 136; Warren II, *Cole in Management of Pain in Cancer*, Schiffin (1956).

122. Bonica and Backus, *supra* note 115, at 22; Bonica, *supra* note 115, at 37.

123. *Ibid.*

number of these situations may have been brought about by premature or excessive application of these drugs.¹³⁹ Psychotherapy "unfortunately . . . has barely been explored"¹⁴⁰ in this area, although a survey conducted on approximately 300 patients with advanced cancer disclosed that "over 50 per cent of patients who had received analgesics for long periods of time could be adequately controlled by placebo medication."¹⁴¹ Nor should it be overlooked that nowadays drugs are only one of many ways—and by no means always the most effective way—of attacking the pain problem. Radiation, roentgen and X-ray therapy; the administration of various eutectic

139 "The efficacy of narcotic analgesics, particularly opiates, in managing pain of terminal malignancy, is too well known to warrant discussion. . . . Unfortunately their effectiveness, low cost, and ease of administration—very desirable qualities in any drug—are conducive to improper use by the busy physician. . . . It is well known that the physician tends to consider each case individually so that the pharmacologic properties of the various narcotic drugs are fully exploited to the advantage of the patient. The attitude and practice of some physicians to "snow the patient under because the end is inevitable" denotes lack of understanding of the problem. . . . It is very difficult to estimate the length of life in each individual case. . . . The physician must be alert to the possibility of respiratory depression, headache, anorexia, nausea, vomiting, and will bring on a state of cachexia more rapidly. Moreover, because tolerance develops rapidly, the patient may not obtain adequate relief in the latter stages of the disease, when comfort is so essential, even with massive doses, and he may also become addicted to the drug. . . . The physician must be alert to the possibility of withdrawal symptoms when the amount administered is no longer effective." Bonica and Backus, *supra* note 135, at 24-25; to the same effect is Bonica, *supra* note 135, at 38.

See also Scudlitz and Gross, *supra* note 135, at 17. "Factors facilitating the development of tolerance include the administration of the drug at frequent, regular intervals and the use of successively larger doses. . . . The development of clinically significant tolerance can be delayed by using the alternative of giving the drug at irregular intervals, by limiting the use of addicting drugs to their primary characteristic, analgesia, and not to secondary properties such as sedation. The writing of such an order as '½ gr morphine q. 4 h.' is to be deplored. Addicting analgesics are to be ordered on the basis of pain, not according to the clock or nursing habit." Bonica, *supra* note 135, at 38.

40 "The opium appears to prevail in the medical profession that severe pain is inevitable and must be treated. . . . It is commonly occurs in advanced cancer. Fortunately, this does not appear to be the case in the early stages of cancer. . . . The physician's need for more attention from the family or from the physician, are frequently mistaken for expressions of pain. Reassurance and an understanding approach in presenting a plan of management to the patient are well known palliative remedies, and probably the clue to success of many patients. . . . The physician who is properly trained and who practices his profession without psychiatric training is often helpful to his patient. . . . The patient is expected to be of more value. Unfortunately, the potential therapeutic usefulness of this tool has barely been explored." Lashin and Spencer, *Medical Problems in The Management of Cancer*, 37 Med. Clinics of N. A. 869, 875 (1953).

41 "Placebo" medication is medication having no pharmacologic effect. . . . However, the patients in Montefiore Hospital, N.Y. One clear indication is that "analgesics should be prescribed only after an adequate trial of placebo."

substances, intrathecal alcohol injections and other types of nerve blocking; and various neurosurgical operations such as spinal rhizotomy and sympathectomy, have all furnished striking relief in many cases.¹⁴² These various formidable non-narcotic measures, it should be added, are conspicuously absent from the prolific writings of the euthanasiaists.

That of those who do suffer and must necessarily suffer the requisite pain, many *readily* desire death, I have considerable doubt.¹⁴³ Further, that of those who may desire death at a given moment, many have a fixed and rational desire for death, I likewise have considerable doubt.¹⁴⁴ Finally, taking those who may have such a desire, again I must register a strong note of skepticism that many cannot do the job themselves.¹⁴⁵ It is not that I condone suicide. It is simply that for reasons discussed in subsequent sections of this paper I find it easier to prefer a *laissez-faire* approach in such matters over an approach aided and sanctioned by the state.

The need is only one variable. The incidence of mistake is another. Can it not be said that although the need is not very great it is great enough to outweigh the few mistakes which are likely to

142. See note 135, *supra*.

143. The one thing agreed upon by the eminent physicians Abraham L. Wolbarst, later an officer of the Euthanasia Society of America, and James P. Walsh in their debate on "The Right To Die" was that very, very few people ever really want to die. . . . Walsh reported that in all the time he worked at Mother Alphaeus' Home for the Cripple he never heard one patient express the wish that he "would be better off dead," and "I know, too, that Mother Alphaeus had very rarely heard it." On the other hand," adds Walsh, "I have often heard neurotic patients wish that they might be taken out of existence because they could no longer bear up under the pain they were suffering. . . . They were overcome mainly by self-pity. Above all, they were sympathy seekers. . . . If anyone (patients) were asked no trick questions, but they were simply ready, willing and able to dole out death, . . . Walsh, *Life*, 15, 56, 94. The fact that the "very few incurables may be the will to live, the desire for life, is such an overwhelming force that pain and suffering become bearable and they prefer to suffer rather than die," LeGarde, *supra* note 142, The Forum 330 (1955).

144. The fact that the "very few incurables may be the will to live, the desire for life, is such an overwhelming force that pain and suffering become bearable and they prefer to suffer rather than die," LeGarde, *supra* note 142, The Forum 330 (1955).

145. See text at notes 49 and 52 *supra*.

146. In *Euthanasia—Right or Wrong?* Survey Graphic, May, 1948, p. 241, Selwyn James makes considerable lay of the Euthanasia Society of America's claim that numerous cancer patients phone the society and beg for a doctor who will give them euthanasia. If a person retains sufficient physical and mental ability to look up a number, get to a phone and dial, does he really have to ask *others* to deal him death? That is, it is death he really desires, and not, say, attention or pity.

occur? I think not. The incidence of error may be small in euthanasia, but as I have endeavored to show, and as Professor Williams has not taken pains to deny, under our present state of knowledge appreciable error is inevitable. Some, no matter how severe the pain, no matter how strikingly similar the symptoms, will not be cancer victims or other qualified candidates for euthanasia. Furthermore, among those who are in fact so afflicted, there are bound to be some who no matter how "hopeless" their plight at the moment, would be able to benefit from some treatment. That is, they would have been able to lead relatively normal, reasonably useful lives for, say, six months or a year, if death had not come until it came in its own way in its own time.

How many are "some"? I do not know, but I think they are a good deal more than *de minimis*. The business of predicting what cures or temporary checks or measures of relief from pain are around the corner is obviously an inexact science. And as for error in diagnosis, doctors, as a rule, do not contribute to *True Confessions*.¹⁴⁶ But I venture to say that the percentage and the absolute figures would not be as small, certainly not any smaller, than the grunts of federal habeas corpus petitions to set aside state convictions. Federal habeas corpus so operates that only a handful of petitions are granted and only a small fraction of these cases are ultimately discharged.¹⁴⁷ Yet its continued existence has been able

146. See, e.g., *Proceedings, Symposium on Exfoliative Cytology at 58* (Oct. 23-24, 1951): Banoff; Dr. [Peter] Herbert is to be congratulated on his M.D. thesis for showing that the majority of cases which were operated on and did not have cancer. Most of the time we have a tendency in our enthusiasm not to talk about things like that. . . .

147. During the nine years from 1946 through 1954, only 79 or 1.6% of 4,849 federal habeas corpus applications were granted. In 1954, the percentage was down to 1.3; in 1953 it had fallen below 1 per cent; 3 out of 228 in 1952, 1 out of 100 in 1951. See *United States Supreme Court, Habeas Corpus, 109, 140* (1952): Pollak, *Proposals to Curial Federal Habeas Corpus for State Prisoners: Collateral Attack on the Great Writ*, 66 *Yale L.J.* 50, 53 (1956); Ribble, *A Look at the Policy Making Powers of the United States Supreme Court and the Position of the Individual*, 14 *Wash. & Lee L. Rev.* 167, 174-9 (1957); Schaffer, *Federalism and State Criminal Justice*, 70 *Yale L.J.* 9 (1960). Of course, these figures are not necessarily reflective of the actual proportion of successful cases. Professor Pollak suggests that the very low measure of success is due in no small degree to the difficulties of proof involved in reconstructing trials of the distant past and the ineptness of prisoners handling their own post-conviction litigation. 66 *Yale L.J.* 14-15, while Professor Baker takes the contrary position. 66 *Yale L.J.* 14-15. In any event, the statistics indicate that the tribunals have been correct at least 98.6 (98.47) per cent of the time when their convictions have been challenged, it is not completely amiss to surmise that the state courts may have been right in those few cases where the writs were granted and the prisoners discharged. 22 *Mo. L. Rev.* at 140, 1, for one, and Pollak's reasoning more persuasive, but I think it fair to say that

defended as but another example of the recurrent theme that it is better that many guilty go free than one innocent be convicted.¹⁴⁸ So long as this is the vogue, I do not hesitate—although Williams evidently thinks it is "no contest!"—to pit the two or three or four who might be saved against the hundred who cannot be.

Even if the need for voluntary euthanasia could be said to outweigh the risk of mistake, this is not the end of the matter. That "all that can be expected of any moral agent is that he should do his best on the facts as they appear to him"¹⁴⁹ may be true as far as it goes, but it would seem that where the consequence of error is so irreparable it is not too much to expect of society that there be a *good deal more than one moral agent* "to do his best on the facts as they appear to him." It is not too much to expect for example, that something approaching the protection thrown around one who appears to have perpetrated a serious crime be extended to one who appears to have an incurable disease. Williams' proposal falls far short of this mark.

most defenders of the writ are willing to take the figures as they find them. Yet, of the handful whose petitions were granted, how many actually get relief? In 1953, Mr. Justice Jackson, writing for the last four of the 79, said that the writs were granted by federal district courts, *Brown v. Allen*, 344 U.S. 443, 510 (1953) (dissenting opinion), "the minuscule figure of .15 per cent", as one of the writ's staunchest friends has put it. Pollak, *supra*, at 53.

148. It is not surprising that the cry has gone out that federal habeas corpus is not worth it, that "one swallow does not make a summer." *Baker v. Carr*, 359 U.S. 844, 854 (1959). But the cry is not new. In 1953, Mr. Justice Jackson, concurring in *Brown v. Allen*, 344 U.S. 443, 537 (1953). But these views have not prevailed. As Illinois Supreme Court Justice Walter Schaefer recently observed in his Holmes lecture:

Even with the narrowest focus it is not a needle we are looking for in these stacks of paper, but a needle which will pierce the significance of that single human being and diminishes and we begin to catch a glimpse of the full picture. The aim which justifies the existence of habeas corpus is not fundamentally different from that which informs our criminal law in general, that it is better that a guilty man go free than that an innocent one be punished. To the extent that the small numbers suggest that the standards of the small are being honored in criminal trials we should be gratified; but the continuing availability of the federal remedy is in large part responsible for that result. What is involved, however, is not just the enforcement of debited standards. It is also the creative process of devising specific content into the highest standards of the law. The burden of this text is stilling the meretricious from the worthless appears less facile.

Schaefer, *supra* note 149 at 25-26.

I think Justice Schaefer would agree that his thought is more often articulated in terms of "it is better that a guilty man go free than an innocent be convicted." See, e.g., *Michigan v. Mithell*, 392 U.S. 442, 446 (1968). *Principles of Criminal Law, A Survey and Criticism*, 66 *Yale L.J.* 319, 346 (1957).

II. A LONG RANGE VIEW OF EUTHANASIA

A. *Voluntary v. Involuntary Euthanasia.*

Ever since the 1870's, when what was probably the first euthanasia debate of the modern era took place,¹⁵⁰ most proponents of the movement—at least when they are pressed—have taken considerable pains to restrict the question to the plight of the unbearably suffering incurable who *voluntarily seek* death while most of their opponents have striven equally hard to frame the issue in terms which would encompass certain involuntary situations as well, e.g. the "congenital idiots," the "permanently insane," and the senile.

Clavelle Williams reflects the outward mood of many euthanasists when he scores those who insist on considering the question from a broader angle:

The [English Society's] bill [debated in the House of Lords in 1936 and 1950] excluded any question of compulsory euthanasia, even for hopelessly defective infants. Unfortunately, a legislative proposal is not assured of success merely because it is wielded in a studiously moderate and restrictive form. The method of attack, by those who dislike the proposal, is to use the 'thin edge of the wedge' argument. . . . There is no pro-

150. I. A. Tollenmacher and not since has there been a more persuasive euthanasia—wedge—subsequent plea for voluntary euthanasia. *The New York Times*, 19 Fortnightly Review 218 (1872), in support of a similar proposal the previous year, S. D. Williams, *Euthanasia* (1872), (a book now out of print, but a copy of which is at the British Museum). Tollenmacher's article was bitterly criticized by the editors of *The Spectator*, *Mr. Tollenmacher on The Right To Die*, 46 *The Spectator* 206 (1873) who stated in part:

It appears to be quite evident, though we do not think it is expressly stated in Mr. Tollenmacher's article, that much the strongest arguments to be alleged for putting an end to human sufferings apply to cases where you cannot by any possibility have the consent of the sufferer to that course.

In a letter to the editor, *The Limits of Euthanasia*, 46 *The Spectator* 240 (1873), Mr. Tollenmacher stated:

I tried to make it clear that I disapproved of such relief ever being given without the dying man's express consent. . . . But it is said that all my reasoning would apply to cases like lingering paralysis, where the sufferer might be speechless. I think not. . . . where these safeguards cannot be obtained, the sufferer must be allowed to make his own choice. I do not say that the sufferer must be allowed to make his own choice in the last, saddest moments of his life. I do not say that the sufferer may be anxious to wait what suffering he can, even though the conditions necessary for the relief of other (and perhaps worse) suffering may not exist. . . . I have stated my meaning thus fully, because I believe it is a common misunderstanding of Euthanasia, that it must needs involve some such proceedings as the late Mr. Charles Buxton advocated (not perhaps quite seriously)—namely, the summary extinction of idiots and of persons in their dotage.

I give this reprint to the voluntary euthanasists.

posal for reform on any topic, however conciliatory and moderate, that cannot be opposed by this dialectic.¹⁵¹

Why was the bill "wounded in a studiously moderate and restrictive form?" If it were done as a matter of principle, if it were done in recognition of the ethico-moral-legal "wall of separation" which stands between voluntary and compulsory "mercy-killings," much can be said for the euthanasists' lament about the methods employed by the opposition. But if it were done as a matter of political expediency—with great hopes and expectations of pushing through a second and somewhat less restrictive bill as soon as the first one had sufficiently "educated" public opinion and next a third still less restrictive bill—what standing do the euthanasists then have to attack the methods of the opposition? No cry of righteous indignation could ring more hollow, I would think, than the protest from those utilizing the "wedge" principle themselves that their opponents are making the wedge objection.

In this regard the words and action of the euthanasists are not insignificant.

No sooner had the English Society been organized and a drive to attain "easy death" legislation launched than Dr. Harry Roberts, one of the most distinguished sympathizers of the movement, disclosed some basis for alarm as to how far the momentum would carry:

So far as its defined objects go, most informed people outside the Catholic Church will be in general sympathy with the new Society; but lovers of personal liberty may feel some of that suspicion which proved so well justified when the Eugenics movement was at its most enthusiastic height.

In the course of the discussion at the [1935] Royal Sanitary Institute Congress, two distinguished doctors urged the desirability of legalizing the painless destruction of 'human mental inabilities' in whom improvement is unattainable; and at the inaugural meeting of the Euthanasia Legislation Society, the Chairman of the Executive Committee said that 'they were concerned to-day only with voluntary euthanasia; but, as public opinion developed, and it became possible to form a truer estimate of the value of human life, further progress along preventive lines would be possible. . . . The population was an ageing one, with a larger relative proportion of elderly persons—individuals who had reached a degenerative stage of life. Thus the total amount of suffering and the number of useless lives must increase.'

We need to discriminate very carefully between facilitating the death of an individual at his own request and for his own relief,

151. Williams, pp. 333-34.

and the killing of an individual on the ground that, for the rest of us such a course would be more economical or more agreeable than keeping him alive.¹⁵²

In the 1936 debate in the House of Lords, Lord Ponsonby of Shillinglee, who moved the second reading of the voluntary euthanasia bill, described two appealing actual cases, one where a man drowned his four-year-old daughter "who had contracted tuberculosis and had developed gangrene in the face,"¹⁵³ another where a woman killed her mother who was suffering from "general paralysis of the insane."¹⁵⁴ Both cases of course were of the compulsory variety of euthanasia. True, Lord Ponsonby readily admitted that these cases were not covered by the proposed bill, but the fact remains that they were the *only* specific cases he chose to describe.

In 1950, Lord Clorley once again called the voluntary euthanasia bill to the attention of the House of Lords. He was most articulate, if not too discreet, on excluding compulsory euthanasia cases from coverage:

Another objection is that the bill does not go far enough, because it applies only to adults and does not apply to children who come into the world deaf, dumb and crippled, and who have a much better cause than those for whom the bill provides. That may be so, but we must go step by step.¹⁵⁵

In 1938, two years after the English Society was organized and its bill had been introduced into the House of Lords, the Euthanasia Society of America was formed.¹⁵⁶ At its first annual meeting the following year, it offered proposed euthanasia legislation:

Infant imbeciles, hopelessly insane persons . . . and any person not requesting his own death would not come within the scope of the proposed act.

Charles E. Nixdorff, New York lawyer and treasurer of the society, who offered the bill for consideration, explained to some of the members who desired to broaden the scope of the proposed law, that it was *limited purposely to voluntary euthanasia because public opinion is not ready to accept the broader principle*. He said, however, that the society hoped eventually to legalize the *pulling to death of nonvolunteers* beyond the help of medical science.¹⁵⁷

152. Roberts, *Euthanasia and other Aspects of Life and Death* 7-8 (1946).

153. 103 H.L. Deb. 466, 471 (1936).

154. *Ibid.*

155. 169 H.L. Deb. 551, 559 (1950).

156. N.Y. Times, Jan. 17, 1938, p. 21, col. 8.

157. N.Y. Times, Jan. 27, 1939, p. 21, col. 7 (emphasis added). That the report is correct is shown by the remarks of Nixdorff in the N.Y. Times, Jan. 30, 1939, p. 12, col. 7, wherein he complained only that "the patient who petitions the court for euthanasia should not be

About this time, apparently, the Society began to circulate literature in explanation and support of voluntary euthanasia, as follows:

The American and English Euthanasia Societies, after careful consideration, have both decided that more will be accomplished by devoting their efforts at present to the measure which will probably encounter the least opposition, namely *voluntary euthanasia*. The public is readier to recognize the right to die than the right to kill, even though the latter be in mercy. To take someone's life without his consent is a very different thing from granting him release from unnecessary suffering at his own express desire. The freedom of the individual is highly prized in democracies.¹⁵⁸

The American Society's own "Outline of the Euthanasia Movement in the United States and England" states in part:

1941. A questionnaire was sent to all physicians of New York State asking (1) Are you in favor of legalizing voluntary euthanasia for incurable adult sufferers? (2) Are you in favor of legalizing euthanasia for congenital monstrosities, idiots and imbeciles? Because only 1/5 as many physicians answered 'yes' to question 2 as to question 1, we decided that we would limit our program to voluntary euthanasia.¹⁵⁹

At a meeting of the Society of Medical Jurisprudence held several weeks after the American Society voluntary euthanasia bill had been drafted, Dr. Foster Kennedy, newly elected president of the Society, "urged the legalizing of euthanasia primarily in cases of born defectives who are doomed to remain defective, rather than for normal persons who have become miserable through incurable illness" and scored the "absurd and misplaced sentimental kindness" that seeks to preserve the life of a "person who is not a person." "If the law sought to restrict euthanasia to those who could speak out for it, and thus overlooked these creatures who cannot speak, then, I say as Dickens did, 'The law's an ass'."¹⁶⁰ As pointed out elsewhere, while president of the Society, Dr. Kennedy not only eloquently advocated involuntary euthanasia but strenuously opposed the voluntary variety.¹⁶¹ Is it any wonder that opponents of

described as a "volunteer" and that "the best definition of euthanasia is 'incurable release' rather than 'mercy killing or even mercy death' because 'being killed' is associated with fear, injury, and the desire to escape." 158. Mr. Frank Hunsan of the University of California Medical School quotes such literature in *Euthanasia*, 99 J. Nerv. & Mental Diseases 640, 643 (1943).

159. *Id.* at 643.

160. N.Y. Times, Feb. 14, 1939, p. 22, col. 6.

161. See note 72 *supra* and accompanying text.

Repuille is reported to have said: "Don't, can't you see I have some birds here." *Ibid.*

Repuille was found guilty of manslaughter in the second degree, N.Y. Times, Dec. 19, 1941, p. 1; and received a suspended sentence of 5-10 years, N.Y. Times, Jan. 25, 1941, p. 44, col. 1.

Subsequently, Repuille's petition for naturalization was dismissed on the ground that he had not possessed "good moral character" within the five years preceding the filing of the petition. In an opinion which makes Repuille the "mercy killing" perhaps best known to lawyers today, Judge Learned Hand said in part:

It is not surprising that the jury which tried Repuille did not feel any moral repulsion at his crime. Although it was inexcusable murder in the first degree, not only did they bring in a verdict that was flatly in the face of the facts and utterly absurd—for manslaughter in the second degree presupposes that the killing has not been deliberate—but they coupled even that with a recommendation which showed that in plain, from the sentence which he imposed, that the judge could not have seriously disagreed with their recommendation.

Left at large as we are, without means of verifying our conclusion, and without means of understanding the motives which may have actuated the jury, we are tentative, and not much is gained by discussion. We can say no more than that, . . . we feel reasonably secure in holding that only a minority of virtuous persons would deem the practice morally justifiable, while it remains in private hands, even when the provocation is as overwhelming as it was in this instance.

Repuille v. United States, 165 F.2d 152, 153 (2d Cir. 1947).

Repuille was charged with the murder of a well-to-do lawyer who was charged with electrocuting his 6-month-old mongrel son by wrapping a frayed electric light cord about him and placing him in wet diapers—on a silver serving tray to form a contact. Noxon claimed it was all an accident. N.Y. Times, Sept. 28, 1943, p. 27, col. 2; Sept. 29, 1943, p. 23, col. 7; Oct. 29, 1943, p. 21, col. 7; Jan. 14, 1944, p. 21, col. 3; July 7, 1944, p. 30, col. 2; July 8, 1944, p. 30, col. 2. After initial conviction for second degree murder, N.Y. Times, July 10, 1944, p. 30, col. 2. His death sentence was commuted to life, but in granting the clemency, Gov. M. J. Tobin of Massachusetts did not explain the "extenuating circumstances" other than to caution that a "mercy-killing, so-called," could not be considered an extenuating circumstance and was not a factor in his decision. N.Y. Times, Aug. 8, 1946, p. 14, col. 1. To illustrate the proviso that he would live under parole supervision for life upon release from prison. N.Y. Times, Dec. 30, 1948, p. 13, col. 5. Shortly thereafter, Noxon was paroled. N.Y. Times, Jan. 4, 1949, p. 16, col. 3; Jan. 8, 1949, p. 30, col. 4. He was disbarred the following year. N.Y. Times, May 30, 1950, p. 2, col. 7.

183. Virginia Braundorf was a spastic-scribbled 29-year-old "helpless" quadriplegic who was confined to a hospital bed for most of her life. She talked in gibbling sounds which only her father could understand. At one time, to keep her home and well attended, her father, Eugene, a symphony musician, had held down four jobs simultaneously, but he finally resigned himself to leaving her at a private sanitarium. Worried about his health and the fate of his daughter if he should die, Braundorf took her from the sanitarium on a pretense, slipped her out of a padded hospital bed, and shot her on the forehead. She died. The jury found her guilty of first degree temporary insanity. *Murder or Mercy?*, Time, June 5, 1950, p. 20; N.Y. Times, May 23, 1950, p. 25, col. 4.

The prosecution argued that the girl was "human" and "had a right to live" and accused Braundorf of slaying her because she was a "burden on his pocketbook." N.Y. Times, May 23, 1950, p. 25, col. 4. The prosecution also charged that Braundorf had fired two shots into his own chest, and, on reviving, shot himself twice more.

These situations are all quite moving. So much so that two of the strongest presentations of the need for voluntary euthanasia, free copies of which may be obtained from the American Society, lead off with sympathetic discussions of the *Brownhill* and *Greenfield* cases.¹⁸¹ This, it need hardly be said, is not the way to honor the voluntary-involuntary boundary. Not the way to ease the pressure to legalize at least this type of involuntary euthanasia as well if any changes in the broad area are to be made at all.

Nor, it should be noted, is Williams free from criticism in this regard. In his discussion of "the present law," apparently a discussion of voluntary euthanasia, he cites only one case, *Simpson*, an involuntary situation.¹⁸² In his section on "the administration of the law" he describes only the *Sander* case and the "compassionate acquittal" of a man who drowned his four-year-old daughter, a sufferer of tuberculosis and gangrene of the face.¹⁸³ Again, both are involuntary cases. For "some other" American mercy-killing cases, Williams refers generally to an article by Helen Silving,¹⁸⁴ but two of the three cases he seems to have in mind are likewise cases of involuntary euthanasia.¹⁸⁵

That the press and general public are not alone in viewing an act as a "mercy killing," lack of consent on the part of the victim notwithstanding, is well evidenced by the recent deliberations of the 1949. In *The Doctor Looks At Euthanasia* 149 Medical Record 354 (1949). Dr. Wolbarst describes the *Brownhill* case as an "act of mercy based on pure mother-love" for which, thanks to the growth of the euthanasia movement in England, "it is doubtful that this poor woman even would be put on trial at the present day."

In *Taking Life Legally—Magazine Digest*—(1947), Louis Greenfield's testimony is set against the law of man, but not against the law of God.¹⁸⁶ The acquittal of Mr. Greenfield is indicative of a general attitude towards euthanasia, or "mercy killing," as the popular press phrases it; the mercy killer can usually count on the sympathy and understanding of the court—and his freedom.

185. Williams, p. 319 and n. 9. For a discussion of the *Simpson* case, see note 177 *supra*.

186. Williams, p. 320. For a discussion of the *Sander* case, see note 172 *supra*. The other case at issue in this note, p. 326 n. 5, is the same one described by Lord Pannik in the 1936 House of Lords debate. See text at note 153 *supra*.

187. Williams, p. 328. Williams does not cite to any particular page of the thirty-nine page Silving article, *Euthanasia: A Study In Comparative Criminal Law*, 103 U. of Pa. L. Rev. 350 (1954), but in context he appears to allude to pp. 353-54 of the article.

188. In addition to the *Sander* case, the cases Williams makes apparent reference to are the *Flight* case, see notes 173-76 *supra* and accompanying text; the *Braundorf* case, see note 183 *supra*; and the *Mink* case, see note 17 *supra*. Only in the *Mink* case was there apparently euthanasia by request.

Royal Commission on Capital Punishment.¹⁸⁸ The Report itself described "mercy killings" as "for example, where a mother has killed her child or a husband has killed his wife from merciful motives of pity and humanity."¹⁸⁹ The only specific proposal to exclude "mercy killings" from the category of murder discussed in the Report is a suggestion by the Society of Labour Lawyers which disregards the voluntary-involuntary distinction:

If a person who has killed another person proves that he killed that person with the compassionate intention of saving him physical or mental suffering he shall not be guilty of murder.¹⁹⁰

Another proposal, one by Hector Hughes, M. P., to the effect that only those who "maliciously" cause the death of another shall be guilty of murder,¹⁹¹ as likewise treated the voluntary and involuntary "mercy killer" as one and the same.

Testimony before the Commission underscored the great appeal of the involuntary "mercy killings." Thus, Lord Goddard, the Lord Chief Justice, referred to the famous *Brownhill* case, which he himself had tried some fifteen years earlier, as "a dreadfully pathetic case."¹⁹² "The son," he pointed out, "was a hopeless inebriate, more than inebriate, a mindless idiot."¹⁹³

Mr. Justice Humphreys recalled "one case that was the most pathetic sight I ever saw,"¹⁹⁴ a case which literally had the trial judge, Mr. Justice Hawkins, in tears. It involved a young father

188. According to the Royal Warrant, the Commission was appointed in May, 1949, "to consider and report whether liability under the criminal law in Great Britain to suffer capital punishment should be retained, and if so, in what circumstances, and whether the existing system of capital punishment should be abolished." Royal Commission on Capital Punishment, Report, Cmd. No. 8912, at p. iii (1953) (called henceforth the Royal Commission Report). For an account of the circumstances which led to the appointment of the Commission, see *Prever, The English Homicide Act of 1957, an Attempt to Revise the Law of Murder*, 57 Colum. L. Rev. 624, 629 (1957).

189. "It was agreed by almost all witnesses" that it would "often prove extremely difficult to distinguish killings where the motive was merciful 'from those where it was not'." Royal Commission Report, at Para. 179 (1953). Thus the Commission "reluctantly concluded that 'it would not be possible to frame and apply a definition which would satisfactorily cover the cases.'" *Id.* at para. 180.

190. Royal Commission Report at para. 180 (1953).

191. Minutes of Evidence, pp. 219-20 (Dec. 1, 1949). Mr. Hughes, however, would try the apparent "mercy killer" for murder rather than for manslaughter "because the evidence should be considered not in terms of the motive but in terms of the act." *Id.* at para. 2825. "[T]he man should rest upon the person so charged to prove that it was not a malicious, but a merciful killing." *Id.* at para. 2826.

192. Minutes of Evidence, para. 3120 (Jan. 5, 1950). The Lord Chief Justice did not refer to the case by name, but his reference to *Brownhill* is unmistakable. For an account of this case, see note *infra* at para. 3120. Minutes of Evidence, para. 3120 (Jan. 5, 1950). *Id.* at para. 3315.

who smothered his infant child to death when he learned the child had contracted syphilis from the mother (whose morals turned out to be something less than repressed) and would be blind for life. "That," Mr. Justice Humphreys told the Commission, "was a real 'mercy killing'."¹⁹⁵

The boldness and daring which characterizes most of Glanville Williams' book thus perceptibly when he comes to involuntary euthanasia proposals. As to the senile, he states:

At present the problem has certainly not reached the degree of seriousness that would warrant an effort being made to change traditional attitudes toward the sanctity of life of the aged. Only the grimmest necessity could bring about a change that, however cautious in its approach, would probably cause apprehension and deep distress to many people, and inflict a traumatic injury upon the accepted code of behaviour built up by two thousand years of the Christian religion. It may be however, that as the problem becomes more acute it will itself cause a reversal of generally accepted values.¹⁹⁶

To me, this passage is the most startling one in the book. On page 348 Williams invokes "traditional attitudes towards the sanctity of life" and "the accepted code of behaviour built up by two thousand years of the Christian religion" to check the extension of euthanasia to the senile, but for 347 pages he had been merrily rolling along debunking both. Substitute "cancer victim" for "the aged" and Williams' passage is essentially the argument of many of his opponents on the voluntary euthanasia question.

The unsuppressed comment that "the problem [of senility] has certainly not reached the degree of seriousness" to warrant euthanasia is also rather puzzling, particularly coming as it does after an observation by Williams on the immediately preceding page that "it is increasingly common for men and women to reach an age of 'second childhood and mere oblivion,' with a loss of almost all adult faculties except that of digestion."¹⁹⁷

How "serious" does a problem have to be to warrant a change in these "traditional attitudes"? If, as the statement seems to indicate, "seriousness" of a problem is to be determined numerically, the problem of the cancer victim does not appear to be as substantial as the problem of the senile.¹⁹⁸ For example, taking just the 95,837

196. *Id.*

197. Williams, p. 348.

198. *Id.* at 347.

199. Of all first admissions to New York State Civil Hospitals for mental disorders in 1950, some 5,618 patients—or more than one third—were classified as cerebral arteriosclerosis or senile cases. There were 3,599

first admissions to "public prolonged-care hospitals" for mental diseases in the United States in 1955, 23,561—or one fourth—were cerebral arteriosclerosis or senile brain disease cases.¹⁹⁹ I am not at all sure that there are 20,000 cancer victims per year who die unbearably painful deaths. Even if there were, I cannot believe that among their ranks are some 20,000 per year who, when still in a rational state, so long for a quick and easy death that they would avail themselves of legal machinery for euthanasia.²⁰⁰

If the problem of the incurable cancer victim "has reached the degree of seriousness that would warrant an effort being made to change traditional attitudes toward the sanctity of life," as Williams oliviously thinks it has, then so has the problem of senility. In any event, the senility problem will undoubtedly soon reach even Williams requisite degree of seriousness:

A decision concerning the senile may have to be taken within the next twenty years. The number of old people are increasing by leaps and bounds. Pneumonia, 'the old man's friend' is now checked by antibiotics. The effects of hardship, exposure, starvation and accident are now minimized. Where is this leading us? . . . What of the drooling, helpless, disorientated old man or the doulthy incontinent old woman lying log-like in bed? Is it here that the real need for euthanasia exists?²⁰¹

If, as Williams indicates, "seriousness" of the problem is a major criterion for euthanatizing a category of unfortunates, the sum total of mentally deficient persons would appear to warrant high priority, indeed.²⁰²

psychoses with cerebral arteriosclerosis and 2,439 senile psychoses. In the case of cerebral arteriosclerosis this represented a 600% numerical increase over 1900, and in the case of senile psychoses a 100% increase in 1920. The senile psychoses constituted almost a 400% numerical increase and a 155% increase in the proportion of total first admissions since 1920. Malzberg, *A Statistical Review of Mental Disorders in Later Life*, in *Mental Disorders in Later Life* 13 (Kaplan ed. 1956). Dr. George S. Stevenson classes both psychoses together as "mental illness of aging": "As a rule these patients have very limited prospect of recovery. In fact, they die as they live in the care of the state mental hospital." Stevenson, *Mental Health Planning For Social Action* 41 (1956).

200. U.S. Dept. of Health, Education and Welfare, *Patients in Mental Institutions 1955*, Part II, Public Hospital for the Mentally Ill 21. Some 13,972 were cerebral arteriosclerosis cases; 9,589 had senile brain diseases.

201. See note 143 *supra*.

202. "Mental diseases," 26 Bull. N.Y. Acad. Med. 297, 305 (1950). "Mental diseases," said to be responsible for as much time lost in hospitals as all other diseases combined," Hordreau, *Mind/Health*, *The New Public Health Frontier*, 286 Annals Am. Acad. Pol. & Soc. Sci. 1 (1953). As of about ten years ago, there were "over 900,000 patients under the care and supervision of mental hospitals," Felix and Kramer, *Extent of the Problem of Mental Disorders*, *id.* at 5, 10. Taking only the figures of the *Problem of Mental Disorders*, it is estimated that there are 570,000 cases of psychiatric disorders. "At the end of 1950 there were 577,000 patients . . . in all long-term mental hospitals." *Id.* at 9. This figure represents 2.8

When Williams turns to the plight of the "hopelessly defective infants," his characteristic vim and vigor are, as in the senility discussion, conspicuously absent:

While the Euthanasia Society of England has never advocated this, the Euthanasia Society of America did include it in its original program. The proposal certainly deserves the chief objection to the similar proposal for senile dementia: it does not create a sense of insecurity in society, because infants cannot, like adults, feel anticipatory dread of being done to death if their condition should worsen. Moreover, the proposal receives some support on eugenic grounds, and more importantly on humanitarian grounds—both on account of the parents, to whom the child will be a burden all their lives, and on account of the handicapped child itself. (It is not, however, proposed that any child should be destroyed against the wishes of its parents.) Finally, the legalization of euthanasia for handicapped children would bring the law into closer relation to its practical administration, because juries do not regard parental mercy-killing as murder. For these various reasons the proposal to legalize humanitarian infanticide is put forward from time to time by individuals. They remain in a very small minority, and the proposal may at present be dismissed as politically insignificant.²⁰³

It is understandable for a reformer to limit his present proposals for change to those with a real prospect of success. But it is hardly reassuring for Williams to cite the fact that only "a very small minority" has urged euthanasia for "hopelessly defective infants" as the only reason for not pressing for such legislation now. If, as Williams sees it, the only advantage voluntary euthanasia has over the involuntary variety lies in the organized movements on its behalf, that advantage can readily be wiped out.

In any event, I do not think that such "a very small minority" has advocated "humanitarian infanticide." Until the organization of the English and American societies led to a concentration on the voluntary type, and until the by-products of the Nazi euthanasia program somewhat embarrassed, if only temporarily, most proponents of involuntary euthanasia, about as many writers urged one type as another.²⁰⁴ Indeed, some euthanasiaists have taken consider-

per 1,000 population, and a "fourfold increase in number of patients and a twofold increase in ratio of patients to general population since 1903." *Ibid.* During 1950, the state, county and city mental hospitals spent \$390,000.00 in treatment and maintenance of their patients. *Ibid.* at 13.

203. Williams, *supra* note 199, 349-50.

204. In Turano, *Murder by Request*, 36 Am. Mercury 423 (1935), the author goes considerably beyond the title of his paper. He scores the "barbarous social policy" which nurtures "infant monstrosities and hopelessly injured children for whom permanent suffering is the sole joy of living" and "old men and women awaiting slow extinction from the accumulated

able pains to demonstrate the superiority of defective infant euthanasia over incurably ill euthanasia.²⁰⁰

"aliments of sanity," id. at 424, and notes in his discussion of "permissive statutes" that "when the sufferer is not mentally competent, the decision could be left to near relatives and friends." *Id.* at 425. Dr. W. C. Lester refers to the congenital idiots, the incurably sick, the mentally ill and the aged as "that portion of our population which is a heavy and permanent liability." *Id.* at 457, and agrees with others that "there is somewhere a biological limit to altruism, even for man." *Id.* at 458. Dr. Lester has recently eliminated only incurables from his list of mental incompetents. 464 W. W. Gregg similarly advocates euthanasia for all "chronically or hopelessly insane." *The Right to Kill*, 237 No. Am. Rev. 239, 247 (1934) and concludes *id.* at 249.

With the coming of a more rational social order . . . it is possible to foresee the emergence of a society in which incurable such human life as function happily, in order thereby to help bring about a safer and fuller living for that normal humanity which holds the hope of the future.

W. A. Shumaker, in *These Unfit to Live*, 29 L.N. 165, 166-67 (1925) comments:

Could we not devise an acceptable formula, ten thousand idiots annually put to death by state boards of health, would mean no more to us than ten thousand peddlers annually put to death by automobilists do now.

It is impossible to give a common sense reason why an absolute idiot should be permitted to live. His life is of no value to him or to anyone else, and to maintain its existence absorbs the time and energy of others. As a matter of fact, it is a burden to the community. . . . It is a crime to let an idiot live. . . . But why is it that we shrink? And why, though we shrink from such an act, do we find it possible to excuse him who does it?

Is the balance swinging too far toward overconsideration not only for the idiot but for the moron and the lunatic and a too little consideration for the mentally competent and sane?

In 1935 Dr. A. C. Cline, the Rockefeller Institute's famed Nobel Prize winner, took the position that "not only incurables but kidnappers, murderers, habitual criminals of all kinds, as well as the hopelessly insane, should be quietly and painlessly disposed of." *Newsweek*, Nov. 16, 1935, p. 40; *Time*, Nov. 18, 1935, p. 53; *Pro and Con: Right and Wrong of Merry England*, 1 *The Digest* 22 (1935).

"Merry Killing," 33 *Readers Digest*, *Pro & Con*, 94. *Shall We Legalize Involuntary Situations*. The "question presented" was: Should physicians have the legal privilege of putting painlessly out of their sufferings *unintentionally defective, hopelessly incurable, and feeble-minded* patients and incurable criminals? . . . The *Pro* side of the question, of course, that maximum legal and professional safeguards against abuse are set up, including the consent of the patient *when rational and adult*? (Emphasis added.)

The proponents of euthanasia made the pitch for voluntary euthanasia, then shifted to 953: Euthanasia . . . would also do away with our present savage, inhumane that state of mind live on incurably incurable or degraded by the helplessness of congenital idleness.

For the results of a 1937 national poll on the question which covered the problem of "incurably born permanently deformed or mentally handicapped" as well as "persons incurably and painfully ill" see note 200 *infra*, and accompanying text.

200. Dr. Foster Kennedy believes euthanasia of congenital idiots has two major advantages over voluntary euthanasia (1) error in diagnosis and

As for dismissing euthanasia of defective infants as "politically insignificant," the only poll that I know of which measured the public response to both types of euthanasia revealed that 45% favored euthanasia for defective infants under certain conditions while only 37.5% approved euthanasia for the incurably and pain fully ill under any conditions.²⁰¹ Furthermore, of those who favored the mercy killing cure for incurable adults, some 40% would require only family permission or medical board approval, but not the patient's permission.²⁰²

Nor do I think it irrelevant that while public resistance caused Hitler to yield on the adult euthanasia front, the killing of malformed and idiot children continued unimpaired to the end of the war, the definition of "children" expanding all the while.²⁰³ Is it the enlustering experience of the Nazi euthanasia program which has rendered destruction of defective infants presently "politically insignificant"? If so, is it any more of a jump from the incurably and painfully ill to the unorthodox political thinker than it is from the hopelessly defective infant to the same "unsavory character?"

possibility of betterment by unforeseen discoveries are greatly reduced; (2) there is not much to be gained by the incurable and defective; and (3) the crushed by the forthright statement that one is doomed, a necessary communication under a voluntary euthanasia program. Kennedy's views are contained in *Euthanasia: To Be Or Not To Be*, Colliers, May 20, 1939, p. 15, reprinted with the notation that his views remain unchanged, in *Colliers*, *Defective*, 99 Am. P. 72 (1942); *The Problem of Social Control of the Congenitally Defective*, 99 Am. P. 72 (1942); *The Problem of Social Control of the Congenitally Defective*, 99 Am. P. 72 (1942). See also Dr. Wehrman's views on the cure are reduced in the case of insane or defective people. See text at notes 74-76, *supra*.

106, 207. *See* *Fortune Quarterly Survey*, 1X, *Fortune*, July 1937, pp. 96, 106, 207. In the poll of those who took a position on the defective infants favored euthanasia, 40.5% were unconditionally opposed, and 14.5% were undecided. In the case of the incurably ill, only 37.3% were in favor of euthanasia under any set of safeguards, 47.5% were flatly opposed, and 15.2% took no position.

popular opposition to voluntary euthanasia in the United States on the question has shown the Institute of Public Opinion polls found 46% in favor, 54% opposed. A 1947 poll by the same group found only 37% in favor, 54% opposed and 9% of no opinion. For a discussion of these and other polls by various newspapers and a breakdown of the public attitude on the question in terms of age, sex, education, and income, see *Public Opinion Polls on Euthanasia and Mental Defect*, *Conduct in Citizenship Hearings*, 16 U. of Chi. L. Rev. 138, 141-42 and n 11 (1948).

A. Williams notes, however, at 332, a 1919 British Institute of Public Opinion poll found 66% of the British in favor of some form of legal euthanasia.

201. *The Fortune Quarterly Survey*, note 207 *supra*, at 106.
202. *Mitchell and Mielke, Doctors of Infamy* 114 (1949). The Reich Committee for Research on Hereditary Diseases and Constitutional Susceptibility to Severe Diseases, originally dealt only with child patients up to the age of three, but the age limit was later raised to eight, twelve, and apparently even sixteen or seventeen years. *Id.* at 116.

Or is it not so much that the euthanasias are troubled by the Nazi experience as it is that they are troubled that the public is troubled by the Nazi experience?

I read Williams' comments on defective infants for the proposition that there are some very good reasons for euthanizing defective infants, but the time is not yet ripe. When will it be? When will the proposal become politically significant? After a voluntary euthanasia law is on the books and public opinion is sufficiently "educated?"

Williams' reasons for not extending euthanasia—once we legalize it in the narrow "voluntary" area—to the senile and the defective are much less forceful and much less persuasive than his arguments for legalizing voluntary euthanasia in the first place. I regard this as another reason for not legalizing voluntary euthanasia in the first place.

B. *The Parade of Horrors.*

Look, when the messengers cometh, shut the door, and hold him fast at the door; is not the sound of his master's feet behind him?²¹⁰

This is the "wedge principle," the "parade of horrors" objection, if you will, to voluntary euthanasia. Glanville Williams' peremptory retort is:

This use of the 'wedge' objection evidently involves a particular determination as to the meaning of words, namely the words 'if raised to a general line of conduct'. The author supposes, for the sake of argument, that the merciful extinction of life in a suffering patient is not in itself immoral. Still it is immoral, because if it were permitted this would admit 'a most dangerous wedge that might eventually put all life in a precarious condition'. It seems a sufficient reply to say that this type of reasoning could be used to condemn any act whatever, because there is no human conduct from which evil cannot be imagined to follow if it is persisted in when some of the circumstances are changed. All moral questions involve the drawing of a line, but the 'wedge principle' would make it impossible to draw a line, because the line would have to be pushed farther and farther back until all action became vetoed.²¹¹

I agree with Williams that if a first step is "moral" it is immoral wherever a second step may take us. The real point, however, the

210. *11 Kings*, VI, 32, quoted and applied in Sperry, *The Case Against Mercy Killing*, 70 Am. Mercury 271, 276 (1950).

211. Williams, p. 315. At this point Williams is quoting from Sullivan, *Catholicism and the Morality of Euthanasia*, 54 SS (1949). This Catholic teaching on the morality of euthanasia was the subject of the original position of the Catholic Church's position on euthanasia was originally published by the Catholic University of America Press, then republished by the Newman Press as *The Morality of Mercy Killing* (1950).

point that Williams sloughs, is that whether or not the first step is precarious, is perilous, is worth taking, rests in part on what the second step is likely to be.

It is true that the "wedge" objection can always be advanced, the horrors can always be paraded. But it is no less true that on some occasions the objection is much more valid than it is on others. One reason why the "parade of horrors" cannot be too lightly dismissed in this particular instance is that Miss Voluntary Euthanasia is not likely to be going it alone for very long. Many of her admirers, as I have endeavored to show in the preceding section, would be neither surprised nor distressed to see her joined by Miss Euthanasize the Congenital Idiots and Miss Euthanasize the Permanently Insane and Miss Euthanasize the Senile Dementia. And these lasses—whether or not they themselves constitute a "parade of horrors"—certainly make excellent majorities for such a parade:

Some are proposing what is called euthanasia; at present only a proposal for killing those who are a nuisance to themselves; but soon to be applied to those who are a nuisance to other people.²¹²

Another reason why the "parade of horrors" argument cannot be too lightly dismissed in this particular instance, it seems to me, is that the parade has taken place in our time and the order of procession has been headed by the killing of the "incurables" and the "useless";

Even before the Nazis took open charge in Germany, a propaganda barrage was directed against the traditional compassionate nineteenth-century attitudes toward the chronically ill, and for the adoption of a utilitarian, Hegelian point of view. . . . Lay opinion was not neglected in this campaign. Adults were propagandized by motion pictures, one of which, entitled 'I Accuse', dealt entirely with euthanasia. This film depicts the life history of a woman suffering from multiple sclerosis; in it her husband, a doctor, finally kills her to the accompaniment of soft piano music rendered by a sympathetic colleague in an adjoining room. Acceptance of this ideology was implanted even in the children. A widely used high-school mathematics text . . . included problems stated in distorted terms of the cost of caring for and rehabilitating the chronically sick and crippled. One of the problems asked, for instance, how many new housing units could be built and how many marriage-allowance loans could be given to newly wedded couples for the amount of money it cost the state to care for the crippled, the criminal and the insane. . . . The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. *It started with the ac-*

212. Chesterton, *Euthanasia and Murder*, 8 Am. Rev. 486, 490 (1937).

The apparent innocuousness of Germany's "small beginnings" is perhaps best shown by the fact that German Jews were at first excluded from the program. For it was originally conceived that "the blessing of euthanasia should be granted only to [true] Germans."²¹³

Relatively early in the German program, Pastor Braune, Chairman of the Executive Committee of the Domestic Welfare Council of the German Protestant Church, called for a halt to euthanasia measures "since they strike sharply at the moral foundations of the nation as a whole. The inviolability of human life is a pillar of any social order."²¹⁴ And the pastor raised the same question which euthanasia opponents ask today, as well they might, considering the disinclination of many in the movement to stop at voluntary "mercy killings": Where do we, how do we, draw the line? The good pastor asked:

How far is the destruction of socially unfit life to go? The mass methods used so far have quite evidently taken in many people who are to a considerable degree of sound mind. . . . Is it intended to strike only at the utterly hopeless cases—the idiots and imbeciles? The instruction sheet, as already mentioned, also lists senile diseases. The latest decree by the same authorities requires that children with serious congenital disease and malformation of every kind be registered, to be collected and processed in special institutions. This necessarily gives rise to grave apprehensions. Will a line be drawn at the tubercular? In the case of persons in custody by court order euthanasia measures have evidently already been initiated. Are other abnormal or anti-social persons likewise to be included? Where is the borderline? Who is abnormal, hopelessly sick?²¹⁵

Williams makes no attempt to distinguish or minimize the Nazi Germany experience. Apparently he does not consider it worthy of mention in a euthanasia discussion. There are, however, a couple of obvious arguments by which the Nazi experience can be minimized. War came he would effectuate the policy of euthanasia since in the general upheaval of war the open resistance to be anticipated on the part of the church would not be the potent force it might otherwise be. Mitscherlich and Mielke *infra* at 91.

Certain petitions to Hitler by parents of malformed children requesting autopsies for "mercy deaths" seem to have played a part in definitely making up his mind. *Ibid.*

214. Defendant Viktor Brack, Chief Administrative Officer in Hitler's private chancellery, so testified at the Nuremberg Medical Trial, 1 Trials of War Criminals Before the Nuremberg Military Tribunal, 40 (1949), 100 (1949), 207 (1949), 208 (1949), 215. Mitscherlich and Mielke, *op. cit.* *infra* note 213, at 107.

215. *Ibid.* According to testimony at the Nuremberg Medical Trial, although they were told that "only incurable patients, suffering severely, were involved," even the medical consultants to the program were "not quite clear on where the line was to be drawn." *Ibid.* at 94.

reference of the attitude, *hinc in the euthanasia movement, that there is such a thing as life not worthy to be lived*. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the minority small wailed-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitatable sick.²¹⁶

213. Alexander, *Medical Science Under Dictatorship*, 241. New England Journal of Medicine 39, 44, 46 (1949) (emphasis added). To the same effect is Joy, *Naazi War Crimes of a Medical Nature*, 139 J.A.M.A. 131, 132 (1949), concluding that the practice of euthanasia was a factor which led to the "unethical, unscientific, unhygienic, unethically ill, unethically and politically unpalatable" (1949), 132 (1949), noting that one of the arguments the Nazis employed to combine their criminal medical experiments was that "it is right to take the life of useless and incurable persons, which as they point out has been suggested in England and the United States, then it is right to take the life of persons who are destined to die for political reasons." *Ibid.* at 132. Alexander also notes that the Nazis used both expert medical advisors to the prosecution at the Nuremberg Trials.

See also the November 25, 1940 entry to Shirer, *Berlin Diary* 454, 458-59 (1941).

I have at last got to the bottom of these 'mercy killings'. It's an evil tale. I have seen the evidence and I have seen the approval of the German government, is systematically putting to death the mentally deficient population of the Reich. . . . X, a German told me yesterday that relatives are rushing to get their kin out of private asylums and out of the clutches of the authorities. He says the Gestapo is doing to death persons who are merely suffering temporarily from mental illness. . . . What is still unclear to me is the motive for these murders. Germans themselves advance three:

3. That they are simply the result of the extreme Nazis deciding to carry out their eugenic and sociological ideas.

The third motive seems most likely to me. For years a group of radical Nazi sociologists who were instrumental in introducing the sterilization laws have pressed for a national policy of eliminating the mentally unfit. They say they have disciples among many sociologists in other lands, and perhaps they have. Paragraph two of the form letter to the relatives plainly bears the stamp of the sociological thinking: "The child is born with a serious mental and physical ailment, his death, which would save him from a lifelong institutional sojourn, is to be regarded merely as a release."

This contemporaneous report is supported by evidence uncovered at the Nuremberg Medical Trial. Thus, on August, 1940 form letter to the relatives of a "deceased mental patient states in part: 'Because of her grave mental illness she is to be released.' . . . Because of her grave mental illness she is to be released." This form letter is reproduced in Mitscherlich and Mielke, *Doctors of Infamy* 104 (1949). Dr. Alexander Mitscherlich and Mr. Fred Mielke attended the trial as delegates chosen by a group of German medical societies and universities. They were the chief defendants at the Nuremberg Medical Trial. Karl Hanfstaengl, Reich Commissioner for the Propaganda and personal physician to Hitler, the Führer has indicated in 1935 that if

One goes something like this: It is silly to worry about the prospects of a dictatorship utilizing euthanasia "as a pretext for putting inconvenient citizens out of the way. Dictatorships have no occasion for such subterfuges. The firing squad is less boldier,"²¹⁷ the reason why this counter argument is not too reassuring, however, is again I may be permitted to be so unkind as to meet speculation with a concrete example to the contrary, is that Nazi Germany had considerable occasion to use just such a subterfuge.

Thus, Dr. Leo Alexander observes:

It is rather significant that the German people were considered by their Nazi leaders more ready to accept the exterminations of the sick than those for political reasons. It was for that reason that the first exterminations of the latter group were carried out under the guise of sickness. So-called "psychiatric experts" were dispatched to survey the inmates of camps with the specific order to pick out members of racial minorities and political offenders from occupied territories and to dispatch them to killing centers with specially made diagnoses such as that of "incurable German later" applied to a number of prisoners who had been active in the Czech underground.²¹⁸

A large number of those marked for death for political or racial reasons were made available for "medical experiments involving the use of involuntary human subjects."²¹⁹

The "hunting season" in Germany officially opened when, Hitler signed on his own letterhead, a secret order dated September 1, 1941, which read:

Reichsleiter (Boulcher and Dr. Brandt, M.D., are charged with the responsibility of enlarging the authority of certain physicians, to be designated by name, in such a manner that persons who, according to human judgment, are incurable can, upon a more careful diagnosis of their condition of sickness, be accorded a mercy death.²²⁰

217 *Id.* & *Con. Shalt We Legalize "Mercy Killing",* 33 *Readers Digest*, Nov. 1938, p. 94 at 96.

218 Leo Alexander, *supra* note 213, at 41. Dr. Alexander Mitscherlich and Fritz Mauthner, *supra* note 213, at 41.

219 The granting of "leave and" in the case of incurable mental patients and malformed or idiot children may be considered to be still within the legitimate sphere of medical discussion. But as the "unwilling process" continued, it moved more and more openly as purely political and ideological criteria for death, whether the subjects were considered incurable or not. The "unwilling process" had only become more understandable to the general public when the "unwilling process" became more and more obvious. The camouflage around these murderous intentions is revealed especially by proof that in the concentration camps prisoners were selected by the same medical consultants who were simultaneously sitting in judgment over the destiny of mental institution inmates. Mitscherlich and Mielke, *op. cit. supra* note 213, at 41.

220 This is the translation rendered in the judgment of the Military Tribunal I, 2 Trials of War Criminals Before the Nuremberg Military Tribunal

Physicians asked to participate in the program were told that the secrecy of the order was designed to prevent patients from becoming "too agitated" and that it was in keeping with the policy of not publicizing home front measures in time of war.²²¹

About the same time that aged patients in some hospitals were being given the "mercy" treatment,²²² the Gestapo was also "systematically putting to death the mentally deficient population of the Reich."²²³

The courageous and successful refusal by a Protestant pastor to deliver up certain cases from his asylum²²⁴ well demonstrates that even the most totalitarian governments are not always indifferent to the feelings of the people, that they do not always feel free to resort to the firing squad. Indeed, vigorous protests by other ecclesiastical personalities and some physicians, numerous requests of various public prosecutors for investigation of the circumstances surrounding the mysterious passing away of relatives, and a generally aroused public opinion finally caused Hitler to yield, if only temporarily, and in August of 1941 he verbally ordered the dissolution of the Council Law No. 196 (1930) ("The Medical Case"). A slightly different but substantially identical translation appears in Mitscherlich and Mielke, *op. cit. supra* note 213 at 92. The letter, Document 380-S, "Conspiration Euthanasie," as written in the original German, may be found in *supra* note 213 at 92. The German text of the Council Law No. 196 (1930) for conflicting views on whether or not the order was back-dated, compare Mitscherlich and Mielke, *op. cit. supra* with Koessler, *Euthanasia In The Hadamar Sanatorium and International Law*, 43 *J. Crim. L. & C.P.S.* 735, 737 (1953).

221 Mitscherlich and Mielke, *op. cit. supra* note 213, at 93-94.

222 The large hospitals and nursing homes in the United States and England which had elderly people in the hospital were dying in increasing numbers, and dying on certain days." Straight, *Germany Executes Her "Unfit",* 104 *New Republic* 627 (1941). Such incidents led a German bishop to ask the Supreme Sacred Congregation whether it is right to kill those "who, although they have committed no crime deserving death, yet, because of mental or physical defects are no longer able to benefit the nation, and are considered a burden to the state, and who, in addition, lack the necessary strength." *Ibid.* The answer was, of course, in the negative, *ibid.* but "it is doubtful if the mass of German Catholics, even if they learned of this statement from Rome, which is improbable, understood what it referred to. Only a minority in Germany knew of the 'mercy deaths'." Shurer, *op. cit. supra* note 213 at 69 n. 1. *Id.* *supra* note 213 at 654.

223 "Last summer, it seems Pastor von Bodelschwingh was asked to deliver up certain of his worst cases to the authorities. Apparently he got wind of what was in store for them. He refused. The authorities insisted. Pastor von Bodelschwingh hurried to Berlin to protest.

Pastor von Bodelschwingh returned to Hebel. The local Gauleiter ordered his arrest. This time the Gauleiter proceeded. The local Gauleiter most popular man in his province. To arrest him in the middle of war would stir up a whole world of unnecessary trouble. He himself declined to arrest the man. Let the Gestapo take the responsibility; he wouldn't. This was just before the night of September 18, 1940. The bombing of the Bebel asylum followed. I understand why a few people wandered as to who dropped the bomb." Shurer, *op. cit. supra* note 213 at 454-55.

continuation of the adult euthanasia program. Special gas chambers in Hadamar and other institutions were dismantled and shipped to the East for much more extensive use of Polish Jews.²²⁴ Perhaps it should be noted, too, that even dictatorships fall prey to the inertia of big government:

It is . . . interesting that there was so much talk against euthanasia in certain areas of Germany, particularly in the region of Wieselbaden, that Hitler in 1943 asked Himmler to stop it. But, it had gained so much impetus by 1943 and was such an easy way in crowded concentration camps to get rid of undesirable and make room for newcomers, that it could not be stopped. The wind had become a whirlwind.²²⁵

Another obvious argument is that it just can't happen here. I hope not, I think not.

But then, neither did I think that tens of thousands of perfectly loyal native-born Americans would be herded into prison camps without proffer of charges and held there for many months, even years, because they were of "Japanese blood"²²⁶ and, although the

²²⁴ Mitchell and Mickle, *op. cit.* *supra* note 213, at 113-114; Koessler, *supra* note 219, at 739.

²²⁵ *Japanese War Crimes of a Medical Nature*, 33 *Federation Bulletin* 113-14 (1947).

²²⁶ As Justice Murphy pointed out in his dissenting opinion in *Korematsu v. United States*, 323 U.S. 214, 241-42 (1944):

No adequate reason is given for the failure to treat these Japanese Americans on an individual basis by holding investigations and hearings to separate the loyal from the disloyal, as was done in the case of the Italian-Americans. . . . It is asserted merely that the loyalty of this group "were unknown and time was of the essence." Yet nearly four months elapsed after Pearl Harbor before the first exclusion order was issued; nearly eight months went by until the last order was issued; and the last of these "subversive" persons was not actually removed until almost eleven months after the date of declaration of war. . . . The conditions were not such as to warrant a declaration of martial law adds strength to the belief that the factors of time and military necessity were not as urgent as they have been represented to be. Moreover, there was no adequate proof that the Federal Bureau of Investigation and the military authorities were in any danger of being misled by the activities of the Japanese-American community. . . . Nor is there any denial of the fact that not one person of Japanese ancestry was accused or convicted of espionage or sabotage after Pearl Harbor while they were still free, a fact which is some evidence of the loyalty of the vast majority of these individuals. . . . It seems incredible under these circumstances it would have been impossible to hold loyalty hearings for the mere 112,000 persons involved—or at least for the 70,000 American citizens—especially when a large part of this number represented children and elderly men and women. . . . Justice Murphy then went on to note that, since over 70,000 German and Italian aliens and in six months freed 64,000 from internment and from any special restrictions. 354 U.S. 242 n. 16.

See generally Rotlow, *The Japanese American Cases—A Disaster*, 54 *Yale L.J.* 489 (1945), a tale well calculated to keep you in anger and shame.

general who required these measures emitted considerable ignorance and bigotry,²²⁷ his so-called military judgment would be largely sustained by the highest court of the land. The Japanese American experience of World War II undoubtedly fell somewhat short of first-class Nazi tactics, but we were getting warm. I venture to say it would not be too difficult to find American citizens of Japanese descent who would maintain we were getting very warm indeed.

In this regard, some of Justice Jackson's observations in his *Korematsu* dissent²²⁸ seem quite pertinent:

All who observe the work of courts are familiar with what Judge Cardozo described as 'the tendency of a principle to expand itself to the limit of its logic.' [Nature of the Judicial Process, p. 51.] A military commander may overstep the bounds of constitutionality, and it is an incident. But if we review and approve, that passing incident becomes the doctrine of the Constitution. There it has a generative power of its own, and all that it creates will be in its own image. Nothing better illustrates this danger than does the Court's opinion in this case. It argues that we are bound to uphold the conviction of *Korematsu* because we upheld one in *Hirabayashi v. United States*, 320 U.S. 81, when we sustained these orders in *so far as they applied a curfew requirement to a citizen of Japanese ancestry*. I think we should learn something from that experience.

In that case we were urged to consider only the curfew feature, that being all that technically was involved, because it was the only count necessary to sustain *Hirabayashi's* conviction and sentence. We yielded, and the Chief Justice guarded the opinion as carefully as language will do. . . . However, in spite of our

²²⁷ See, e.g., General J. L. Dewitt's Final Recommendation to the Secretary of War, *U.S. Army, Western Defense Command, Final Report, Japanese Evacuation from the West Coast, 1942* (1943) at 32 ("The Japanese race is an enemy race and while many second and third generation Japanese born in this country are loyal and law-abiding citizens, they have become 'Americanized,' the racial strains are undiluted."), and his subsequent testimony, *Hearings Before Subcommittee of House Committee on Naval Affairs on H.R. 30, 78th Cong., 1st Sess.* (1943) at 739-40 ("You needn't worry about the Italians at all except in certain cases. Also, the same for the Germans except in individual cases. But we must worry about the Japanese. They are a different matter. They are a different race. They are well made problems as long as he is allowed in this area—problems which I don't want to have to worry about.") After a careful study, Professor (now Dean) Rotlow took this position:

The dominant factor in the development of this policy was not a military estimate of military necessity, but a racial prejudice against the Japanese. . . . The program of excluding all persons of Japanese ancestry from the coastal area was conceived and put through by the organized minority whose business it has been for forty-five years to increase and exploit racial tensions on the West Coast. The Native Sons and Daughters of the Golden West and their sympathizers were lucky in their general, for General DEWITT amply proved himself to be one of them

Rotlow, *supra* note 226, at 496.
²²⁸ See note 226, *supra*.

limiting words we did validate a discrimination on the basis of ancestry for mild and temporary deprivation of liberty. Now the principle of racial discrimination is pushed from support of mild measures to very harsh ones, and from temporary deprivations to indeterminate ones. And the precedent which it is said requires us to do so is *Hirabayashi*. The Court is now saying that in *Hirabayashi* we did decide the very things we there said we were not deciding. Because we said that these citizens could be made to stay in their homes during the hours of dark, it is said we must require them to leave home entirely; and if that, we are told they may also be taken into custody for deportation; and if that, it is argued they may also be held for some undetermined time in detention camps. How far the principle of this case would be extended before plausible reasons would play out, I do not know.²²⁰

It can't happen here. Well, maybe it cannot, but no small part of our Constitution and no small number of our Supreme Court opinions stem from the fear that it *can happen here unless we darn well make sure that it does not* by adamantly holding the line, by swiftly sniffing out what are or might be small beginnings of what we do not want to happen here. To flick off, as Professor Williams does, the fears about legalized euthanasia as so much nonsense, as a chimerical "parade of horrors," is to sweep away much of the ground on which all our civil liberties rest.

*Boyd*²²¹ the landmark search and seizure case which paved the way for the federal rule of exclusion,²²² a doctrine which now prevails in over twenty state courts as well,²²³ set the mood of our day in treating those accused of crime:

It may be that it is the obnoxious thing in its mildest and least repulsive form; but illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure. . . . It is the duty of courts to be watchful for the constitutional rights of the citizen, and against any stealthy encroachments thereon. Their motto should be *obsta principiis*. . . .²²⁴

²²⁰ 323 U.S. at 246-47.

²²¹ *Boyd v. United States*, 116 U.S. 616 (1886).

²²² See *Weeks v. United States*, 232 U.S. 283 (1914); *Goulet v. United States*, 255 U.S. 298 (1921); *Mohr v. United States*, 335 U.S. 451 (1948); *United States v. Jeffers*, 342 U.S. 48 (1951).

²²³ See *Ann.*, 50 A.L.R. 2d 531, 536, 556-560 (1956).

²²⁴ 116 U.S. 616, 635. The search and seizure cases contain about as good an articulation of the "wedge principle" as one can find anywhere, and it is perhaps the one turn in the recent *Boyd* and *Kearney* cases, where Mr. Justice Black quotes the *Boyd* statement with approval and applies it with vigor.

It is urged that the expansion of military jurisdiction over civilians claimed here is only slight, and that the practical necessity for it is very great. The attitude appears to be that a slight encroachment on the Bill

Recent years have seen the Supreme Court sharply divided on search and seizure questions. The differences, however, have been over *application*, not over the *Boyd-Wheeler* "wedge principle"; not over the view, as the great Learned Hand, hardly the frightened spinster type, put it in an oft-quoted phrase, "that what seems fair enough against a squalid huckster of bad liquor may take on a very different face, if used by a government determined to suppress political opposition under the guise of sedition."²²⁵ And when the dissenters have felt compelled to reiterate the reasons for the principle, test its force be diminished by the failure to apply it in the particular case, and they have groped for the most powerful arguments in its behalf, where have they turned, what have they done? Why, they have employed the very arguments Glanville Williams dismisses so contemptuously. They have cited the Nazi experience. They have talked of the police state, the Knock at the Door, the suppression of political opposition under the guise of sedition. They have trotted out, if you will, the "parade of horrors."²²⁶

of Rights and other safeguards in the Constitution need cause little concern. But to hold that these wives could be tried by the military would be to set a precedent. Slight encroachments create new boundaries from which it is not easy to get new territory to capture.

²²⁵ *Reid v. Covert*, 354 U.S. 1, 39-40 (1957).

²²⁶ *United States v. Kirschenblatt*, 16 F.2d 202, 203 (2d cir. 1926).

²²⁷ Thus, in *Brinegar v. United States*, 338 U.S. 160 (1949), it was as well as Jackson the Supreme Court Justice who warned (338 U.S. at 180-81): "Among deprivations of rights, none is so effective in cowering a population as the use of force and the threat of force against every heart. Uncontrolled search and seizure is one of the first and most effective weapons in the arsenal of every arbitrary government. And one need only briefly to have dwelt and worked among a people possessed of many admirable qualities but deprived of these rights to know that the human personality deteriorates and dignity and self-reliance disappear before the harshness of police power. The citizen is subject at any hour to unheralded search and seizure by the police." *United States v. Rabinowitz*, 339 U.S. 56, 82 (1950), Justice Frankfurter cautioned:

By the Bill of Rights the founders of this country subordinated police action to legal restraint, not in order to convenience the guilty but to protect the innocent. And they provide that only the innocent may appeal to these safeguards. The purpose of the Bill of Rights is to prevent prosecution of the guilty does not require jeopardy to the innocent. The knock at the door under the guise of a warrant of arrest for a venial or spurious offense was not unknown to them. . . . We have had grim reminders in our day of their experience. Arrest under a warrant for a conspiracy charge has been familiar practice in the past, it is a commonplace in the police state of Germany and Italy, and it is a country. . . . The progress is too easy from police action unscrutinized by judicial authorization to the police state.

In *Harris v. United States*, 331 U.S. 145 (1947), four Justices dissented in three separate opinions. The first dissent asked (331 U.S. at 163): "How can there be freedom of thought or freedom of speech or freedom of religion if the government can, without warrant, search your house and mine from garret to cellar merely because they are executing a warrant

The lengths to which the Court will go in applying the "wedge principle" in the First Amendment area is well demonstrated by instances where those who have labeled Jews "slimy scum" and likened them to "lizards" and "snakes"²³² or who have denounced them "as all the garbage that . . . should have been burnt in the incinerators"²³³ have been sheltered by the Court so that freedom of speech and religion would not be impaired. Perhaps the supreme example is the *Barnette* case.²³⁴

There, in striking down the compulsory flag salute and pledge, Justice Jackson took the position that "those who begin coercive elimination of dissent soon find themselves exterminating dissenters. Compulsory unification of opinion achieves only the unanimity of the graveyard."²³⁵ "The First Amendment," he pointed out, "was de-

signed to protect the right of the individual citizen to do as he pleases. It is the right of the citizen to do as he pleases, and not the right of the government to do as it pleases. The document was an illicit ration book, tomorrow it may be some suspect piece of literature."

The third dissent voiced fears of "full impact of today's decision" (331 U.S. at 194):

The government established by the Court today can be used as easily by some future government determined to suppress political opposition under the guise of sedition as it can be used by a government determined to undo forgers and defrauders. . . . [I]t takes no stretch of the imagination to picture law enforcement officers arresting those accused of believing, writing or speaking that which is proscribed, accompanied by their own and the government's effort to uncover "anything of a seditious nature."

The third dissent pointed out (331 U.S. at 193):

In view of the residues of zealots to ride roughshod over claims of privacy for any ends that impress them as socially desirable, we should not make inroads on the rights protected by this Amendment. . . . The government could easily establish an ordinance, which imposed a fine of not more than two hundred dollars, for a "breach of peace," defined by the trial court as misbehavior which "sirs the public to anger, invites dispute, brings about a condition of unrest, or creates a disturbance, or if it molests the inhabitants in the enjoyment of peace and quiet by arousing alarm." (331 U.S. at 3.) The Court ruled, per Douglas, J., that the government could not require a person to leave his home and enter a room under Mr. Constitution for a more restrictive view. For the alternative would lead to standardization of ideas either by legislatures, courts, or dominant political or community groups." 337 U.S. at 4-5. The dissenting opinion by Jackson, 337 U.S. 13-21, calls long passages from the speech in question.

232. *Kunz v. New York*, 340 U.S. 290 (1951), overturning a conviction and ten dollar fine for holding a religious meeting without a permit, defendant's permit having been revoked after a hearing by the police commissioner on evidence that he had ridiculed and denounced other religious beliefs at prior meetings. Samples of Kunz's prior preachings may be found in *Justice Jackson's Dissenting Opinion in Kunz v. New York*, 340 U.S. 290 (1951), and for bipartisanship he also denounced Catholicism as "a religion of the devil" and the Pope as "The anti-Christ." *Ibid.*

233. Board of Education v. Barnette, 319 U.S. 624 (1943).
234. 319 U.S. at 641. There was no majority opinion. Chief Justice Stone and Justice Rutledge concurred in Justice Jackson's opinion; Justices Black and Douglas wrote a concurring opinion; and Justice Murphy wrote a separate concurring opinion.

signed to avoid these ends by avoiding these beginnings."²³⁶ Justices Black and Douglas kept in step in their concurring opinion by advancing the view that "the ceremonial, when enforced against conscientious objectors . . . is a handy implement for disguised religious persecution."²³⁷

What were these pernicious "beginnings" again? What was this danger-laden ceremonial again? Why, requiring public school pupils "to participate in the salute honoring the Nation represented by the Flag."²³⁸ Talk about "parades of horror"! This one is an extravaganza against which anything euhanasia opponents can muster is drab and shabby by comparison. After all, whatever else Williams and his allies make "mercy-killings" out to be, *these* beginnings are not "patriotic ceremonies."

The point need not be labored. If the prospects of the police state, the knock on Everyman's door, and wide-spread political persecution are legitimate considerations when we enter "opium smoking dens,"²³⁹ when we deal with "not very nice people" and "sordid little cases,"²⁴⁰ then why should the prospects of the police state and the systematic extermination of certain political or racial minorities be taken any less seriously when we enter the sickroom or the mental institution, when we deal with not very healthy or not very useful people, when we discuss "euhanasia" under whatever trade name?

If freeing some rapist or murderer is not too great a price to pay for the "sanctity of the home", then why is allowing some cancer victim to suffer a little longer too great a price to pay for the "sanctity of life"? If the sheltering of purveyors of "hateful and hate-stirring attacks on races and faiths"²⁴¹ may be justified in the name of a transcendent principle, then why may not postponing the death of the suffering "incurable" be similarly justified?

A FINAL REFLECTION

There have been and there will continue to be compelling circumstances when a doctor or relative or friend will violate The Law On The Books and, more often than not, receive protection.

240. *Ibid.*

241. 319 U.S. at 644.

242. 319 U.S. at 626.

243. See *Opinion of Jackson*.

244. *Kunz v. New York*, 340 U.S. 290 (1951). The point is made in the concurring opinion in *Houts*, From *Gon* to *Gavel*: The Courtroom Recollections of James Mathers of Oklahoma 213-17 (1954).

245. The phrase is that of Mr. Justice Frankfurter, dissenting in *United States v. Rabinowitz*, 339 U.S. 56, 68-69 (1950).
246. The phrase is Justice Jackson's dissenting in *Kunz v. New York*, 340 U.S. 290, 295 (1951).

from "The Law In Action" that this is not to deny that there are other occasions when "The Law On" "The flocks operate to stay the hand of all concerned, among them situations where the patient is in fact (1) presently incurable, (2) beyond the aid of any respite which may come along in his life expectancy, suffering (3) intolerable and (4) unmitigable pain and of a (5) fixed and (6) rational desire to die. That any euthanasia program may only be the opening wedge for more objectionable practices, and that even within the bounds of a "voluntary" plan such as Williams' the incidence of mistake or abuse is likely to be substantial, are not much salubre to me in the above plight.

It may be conceded that in a narrow sense it is an "evil" for such a patient to have to continue to suffer—if only for a little while. But in a narrow sense, long-term sentences and capital punishment are "evils," too.¹⁴⁶ If we can justify the infliction of imprisonment and death by the state "on the ground of the social interests to be protected"¹⁴⁷ then surely we can similarly justify the imposition of death by the state. The objection that the individual is thereby treated not as an "end" in himself but only as a "means" to further the common good was, I think, aptly disposed of by Holmes long ago. "If a man lives in society, he is likely to find himself so treated."¹⁴⁸

246. Perhaps this would not be true if the only purpose of punishment was to reform the criminal. But whatever ought to be the case, this obviously is not. "If it were, every prisoner should be released as soon as it appears clear that he will never repeat his offence, and if he is incurable he should not be punished at all." Holmes, *The Common Law* 42 (1881).

247. Michael and Adler, *Crime, Law and Social Science* 351 (1933).

The utilitarian basis of the criminal law must be the common good, the welfare of a political society determined, of course, by reference to its own ends. Punishment can be justified only as an intermediate means to the ends of deterrence and reformation which, in turn, are means for increasing and preserving the welfare of society. . . . (1881).

248. Holmes, *The Common Law* 44 (1881).

ON COMMON LAW MENS REA

GERHARD O. W. MÜLLER*

PREFACE: *Lambert v. California*; THE ISSUE

One hundred years of American complacency in matters of mens rea, only briefly interrupted by the forward-looking decision in *Morrisette v. United States*,¹ have come to an end with the otherwise insignificant case of *Lambert v. California*.² The subject matter regulated by the ordinance under which the conviction had been rendered in that case could have been any of thousands which are subject to regulation, the offensive ordinance or statute could have come from any jurisdiction,³ anyone might have been the defendant.

Mrs. Virginia Lambert had been accosted by municipal police officers on a street corner in the city of Los Angeles, searched on the spot, apparently for narcotics, handcuffed, shoved into a patrol car and hauled to the precinct station. Further search of her person, as well as questioning, revealed no evidence of any narcotics violation. However, the police did discover that Mrs. Lambert had once been convicted of forgery and that she had not registered with the chief of police, as required by a city ordinance.⁴

Mrs. Lambert had been unaware of the existence of this ordinance. By its own terms the ordinance did not provide for notice to affected parties like Mrs. Lambert, and in fact it was all but conceded that there was no reasonably conceivable way for Mrs. Lambert to learn of her duty to register. "A typical absolute liability offense," everyone might have said and left it at that. Mrs. Lambert was convicted. Her offer to prove ignorance was denied, and the conviction sustained.

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1. 342 U.S. 246 (1952), opinion by Mr. Justice Jackson, ending the spreading development of criminal liability without fault and limiting it to offenses roughly corresponding to the antiquated category of *malum prohibitum*. *Morrisette v. United States*, 392 U.S. 576 (1967).

2. 355 U.S. 225 (1957).

3. E.g., *United States v. Eramdjian*, 155 F. Supp. 914, 924 (S.D. Calif. 1957), upholding a federal registration act similar to that declared unconstitutional in *Lambert v. California*.

4. "The Los Angeles Ordinance makes it a crime for a 'convicted person' to be or remain in the city for more than five days without registering with the chief of police. . . . § 24.03. . . . A convicted person is comprehensively defined by § 22.38 of the ordinance as anyone who has been convicted of a crime defined by § 12.38 of the ordinance. . . . The ordinance has been convicted any place in the world since 1921 of any crime punishable as a felony or of certain other crimes." "Section 11.00 (m) of the Los Angeles Municipal Code provides that failure to comply with any of the mandatory requirements of the code is punishable by a fine of not more than \$500, or by imprisonment in the city jail for not more than six months, or both. Each day's violation is a separate offense." Brief for W. M. Christopher as Amicus Curiae, p. 8, *Lambert v. California*.

Mr. CANADY. Thank you, Professor.
Professor Baron.

**STATEMENT OF CHARLES H. BARON, PROFESSOR OF LAW,
BOSTON COLLEGE LAW SCHOOL**

Mr. BARON. Thank you very much, Mr. Chairman, and thank you for inviting me to testify.

Mr. HYDE. Would you take the microphone?

Mr. BARON. I am sorry. I am used to teaching in classrooms without microphones. I guess I hoped you would hear me even without the mike.

As you already mentioned, Mr. Chairman, I am a professor of law at Boston College Law School, where I teach constitutional law and bioethics. I would add that I also have a degree in philosophy and have taught in philosophy departments and also in medical schools on the subject of ethics and medical ethics as well as legal philosophy.

In January of this year I published, with eight coauthors, including another distinguished criminal law professor, James Vorenberg, who is also the immediate past dean of the Harvard Law School, an article entitled "A Model State Act to Authorize and Regulate Physician-Assisted Suicide." It appeared in the Harvard Journal of Legislation, and I have attached a copy of that article to my testimony which I submitted.

I am here today to talk in favor of States' rights on this issue. I am here today to say that it is my opinion that at least at the present time the legal regulation of physician-assisted suicide is a matter that should be left to the States.

Since the New Jersey Supreme Court's 1976 decision in *Quinlan*, the very difficult question of how the law should protect the individual liberties of terminally ill patients has been dealt with almost exclusively by the courts and legislatures of the 50 States and the District of Columbia.

Over the course of the past 20 years, the State courts have worked together, constantly analyzing each other's decisions and citing them as persuasive precedent to fashion a continually developing and highly nuanced body of common law and constitutional principle that has dealt very effectively with the issues raised by the need to protect patients' rights.

State legislatures were slower than the State courts to respond to the need to protect such rights, but they have all now become a part of the cooperative effort to strike the proper balance in providing legal protection.

Indeed, although the earliest State court decisions, such as *Quinlan* and *Superintendent of Belchertown State Hospital v. Saikewicz*, based their protection of the rights of patients on constitutional grounds, State and Federal, the courts made clear they were leaving a great deal of room for State regulation of the process for protecting those rights, and I would like to take a moment now to point out with glee a mistake, I think, on the part of Professor Kamisar.

I think this is an area where the States, the courts in particular, have found that it is possible to take a step back when they feel they have gone too far.

The earliest cases, *Quinlan* and *Saikewicz*, were both based on a constitutional right to privacy which they found not only in the U.S. Constitution, following *Roe*, but also in their State constitutions, and later cases in both jurisdictions have retreated from the constitutionalization of this area to allow the maximum amount of room for legislation by the States by basing later decisions more on common law principles, which of course can be preempted by State legislation, than on the constitutional law. That is just one area where I think the courts have sometimes tentatively gone very far, then stepped back.

Now State legislatures in all 50 States and the District of Columbia have responded with a very interesting variety of laws which, like the court decisions, have built upon the work of sister States and are continually in the process of development and refinement. All of this, in my opinion, represents State lawmaking at its best.

The work of the State courts in particular is reminiscent of the work done by them in the mid-19th century, which is sometimes called the golden age of the State supreme courts, which in those days was the job of fashioning the common law we inherited from England to deal with the challenges to our society posed by the burgeoning of major business corporations, the coming of the railroads, and the development of the telegraph and other technological innovations.

Thus far, Federal intervention in this area has been minimal and has left the States wide discretion to continue their process of creative lawmaking.

There has been one U.S. Supreme Court decision, the *Cruzan* decision, where all but one of the Justices seemed to join in recognizing the right of a patient in a persistent vegetative state to end her life by refusing food and water. This was not taking somebody off a ventilator. This was not somebody refusing chemotherapy. This was not somebody refusing cardiopulmonary resuscitation. This was somebody who, by proxy, was refusing food and water. And yet the Supreme Court of the United States decided that there was a liberty interest protected by the Constitution to do this.

I would also like to point out that Justice Scalia in that case placed himself among those people who believe there is no difference between refusing life-prolonging treatment and committing suicide, and he so stated in that case because he saw no difference at all. This is Justice Scalia.

The Court, of course, in that case found that, despite the fact there was this constitutional right, that nonetheless Missouri had the right to reasonably regulate the process to make sure that the choice to refuse food and water is the one that this patient would have made.

Now I have heard your suggestions here today. At times we hear suggestions in the press that what we see in the case of the second circuit and ninth circuit opinions is a return of *Roe v. Wade* now to this area, and I actually agree with Dr. Krauthammer that this is really an area that should be dealt with in legislatures, principally State legislatures. I think this the best way for it to be dealt with.

Yet I want to point out, these two cases in many respects are really a far cry from *Roe v. Wade*. Whereas *Roe* laid down a uni-

form national statute for dealing with the complex and difficult problems presented by the phenomenon of abortions, these decisions merely deny the States the power to take the most drastic step of prohibiting physician-assisted suicide under all circumstances, even circumstances where such a denial amounts to extraordinary cruelty and all would agree that no abuse was taking place.

In this respect, these decisions are actually in alignment with the dissenting opinion of Justice Rehnquist, as he then was, in *Roe*, where he said of the Texas statute involved in that case—and now I quote—“The due process clause of the 14th amendment undoubtedly does place a limit, albeit a broad one, on legislative power to enact laws such as this. If the Texas statute were to prohibit an abortion, even where the mother’s life is in jeopardy, I would have little doubt that such a statute would lack a rational relation to a valid State objective under the test stated in *Williamson v. Lee Optical*.”

So I see these decisions as actually coming closer to Justice Rehnquist’s dissenting opinion in *Roe v. Wade*. The issues involved in attempting to legally protect the rights of terminally ill patients are complex, multifaceted, and difficult. We should resist the temptation to deal with them by approaches which are simplistic.

I share with those who oppose the legalization of physician-assisted suicide their concern that a patient’s right to die could, in the wrong hands, be turned into a duty to die. I share also the concern that a power to assist suicide could be used to discriminate.

But at the same time, those who oppose the legalization of physician-assisted suicide must recognize, the move toward legalization is being driven by terminally ill patients themselves, not by those that wish to discriminate against them.

With that, I would like to end with an E-mail note which I received over the Internet from someone I know who is dying of Lou Gehrig’s disease in Rhode Island and who asked me if I would read this to you as part of my statement. I would like to submit this as it just arrived yesterday as part of my statement.

This is from Noel Early who is, from my point of view, still a young man and dying of Lou Gehrig’s disease. He starts out by saying, “Buzz”—that is my nickname, Buzzy—“I wish I could be with you in Washington on Monday when you talk to those Congressmen. If I were there, I would tell them that the terminally ill don’t want their protection, they want them off their backs. They want to be left free to deal with their own lives and their own deaths as they see fit. I am dying of ALS. My doctors have concluded that I should not expect to live much beyond Christmas of this year. I am likely to begin to experience the final stage of the disease in the fall. What I fear is not so much death as what the dying process is sure to become. For people with ALS, this can be really horrific. Why do other people insist on telling me I must suffer for their sake, for the sake of society? I am not a devout Catholic, fundamentalist Protestant, or an Orthodox Jew. I would not impose my values on them. Why must they impose their values on me? And whatever happened to the separation of church and state? If the Congress of the United States is so concerned with protecting them, tell them to pass adequate comprehensive health care legis-

lation. Tell them to make it financially feasible for patients to get the medical care they need so they may in some cases avoid becoming terminally ill. Tell them to repeal Federal drug laws that prevent patients from getting adequate pain medication when they become terminally ill. Tell them that the quality of life is too subjective to legislate.

"Are terminally ill patients depressed and thinking in a distorted fashion? Maybe some of us could be made to feel more accepting about life with a terminal illness. But our depression is likely not to be a function of mental illness, it is likely to be a very rational response to the depressing fact that we are soon to die, and for some of us, no matter what anyone does to comfort us, the dying will be much worse than the death. When my time comes, I pray there will be resources to make my passing humane, comfortable, and successful. I do not wish for that panic-filled moment when the taste of a gun barrel precedes the instant of its firing."

[The prepared statement of Mr. Baron follows:]

PREPARED STATEMENT OF CHARLES H. BARON, PROFESSOR OF LAW, BOSTON COLLEGE
OF LAW

My name is Charles Baron and I am a Professor of Law at Boston College Law School. I teach and write in the areas of Constitutional Law and Law and Bioethics. In addition to my law degree, I have a degree in philosophy, and I have taught courses in Legal Philosophy and Ethics in departments of philosophy and a course in Medical Ethics at a medical school.

In January of this year, I published with eight co-authors an article on physician-assisted suicide which appeared in the Harvard Journal on Legislation. It is entitled: "A Model State Act to Authorize and Regulate Physician-Assisted Suicide." Because the article is short, recent, and deals with many issues which may be of interest to this committee, I have attached a copy as an Exhibit to this testimony.

It is my opinion that, at least at the present time, the legal regulation of physician assisted suicide is a matter that should be left to the States. Since the New Jersey Supreme Court's 1976 decision in In re Quinlan,¹ the very difficult question of how the law should protect the individual liberties of terminally-ill patients has been dealt with almost exclusively by the courts and legislatures of the 50 states and the District of Columbia. Over the course of the past twenty years, the State courts have worked together (constantly analyzing each other's decisions and citing them as persuasive precedent) to fashion a continually developing and highly nuanced body of common law and constitutional

¹ 335 A.2d 647 (N.J. 1976).

principles that have dealt very effectively with the issues raised by the need to protect patients' rights. State legislatures were slower than the State courts to respond to the need to protect such rights, but they have all now become part of the cooperative effort to strike the proper balance in providing legal protection. Indeed, although the earliest State court decisions such as Quinlan and Superintendent of Belchertown State Hospital v. Saikewicz,² based their protection of the rights of patients on constitutional grounds (state and federal), the courts made clear that they were leaving a great deal of room for state regulation of the process for protecting those rights. State legislatures in all 50 states and the District of Columbia have responded with a very interesting variety of laws which, like the court decisions, have built upon the work of sister States and are continually in the process of development and refinement.

All of this, in my opinion, represents State lawmaking at its best. The work of the State courts, in particular, is reminiscent of the work done by them in the mid 19th Century -- the "Golden Age" of State supreme courts -- in refashioning the Common Law we inherited from England to deal with the challenges to our society posed by the burgeoning of major business corporations, the coming of the railroads, and the development of the telegraph and other technological innovations.

Thus far, federal intervention in this area has been minimal and has left the States wide discretion to continue their process of creative lawmaking. There has been one U.S. Supreme Court decision, Cruzan v. Director, Missouri Department of Health,³ in which all but one of the Justices seemed to join in finding that the right of a patient in a persistent vegetative state to end her life by refusing food and water was protected by the the Due Process Clause of the Fourteenth Amendment to the United States Constitution. But the Court made clear that the State of Missouri had a good deal of discretion to decide how best to protect that right -- especially as regards the fundamental matter of the processes for

² 370 N.E.2d 417 (Mass. 1977).

³ 497 U.S. 261 (1990).

establishing that the patient, when competent, would have chosen death over continued life in a persistent vegetative state. In the last two months, two United States Courts of Appeal, have declared State statutes categorically prohibiting assisted suicide under all circumstances to be unconstitutional as applied to acts of physicians assisting terminally ill patients who competently and voluntarily request such assistance.⁴ Both of these courts went out of their way to make clear that they were recognizing very wide discretion on the part of the States involved to regulate physician assisted suicide to protect against potential abuse. Indeed, both courts urged State legislators to pass such legislation.

Although some have complained that these federal decisions amount to "a Roe v. Wade" in the area of the right to die, they are, in actuality, a far cry from Roe. Whereas Roe essentially wrote a uniform national statute for dealing with the complex and difficult problems presented by the phenomenon of abortion, these decisions merely deny the States the power to take the most drastic step of prohibiting physician assisted suicide under all circumstances -- even circumstances where such a denial amounts to extraordinary cruelty and all would agree that no abuse was taking place. These decisions are actually in alignment, in this respect, with the dissenting opinion of Justice Rehnquist (as he then was) in Roe where he said of the Texas statute involved in that case:

The Due Process Clause of the Fourteenth Amendment undoubtedly does place a limit, albeit a broad one, on legislative power to enact laws such as this. If the Texas statute were to prohibit an abortion even where the mother's life is in jeopardy, I would have little doubt that such a statute would lack a rational relation to a valid state objective under the test stated in Williamson v. Lee Optical.⁵

The issues involved in attempting to legally protect the rights of terminally ill patients are complex, multifaceted, subtle, and difficult. We should resist the temptation to deal with them by approaches which are simplistic and driven by shibboleth. I share with those who oppose the legalization of physician assisted suicide their concern that a patient's

⁴ *Compassion in Dying v. State of Washington*, 1996 WL 94848 (9th Cir. (Wash.)); *Quill v. Vacco*, 1996 WL 148605 (2nd Cir. (N.Y.)).

⁵ 410 U.S. 113, 173 (1973) (Rehnquist, J. dissenting).

right to die could, in the wrong hands, be turned into a duty to die. I share also the concern that a power to assist suicide could be used to discriminate against the terminally ill as a disfavored class and could be used as an excuse to deny them needed medical assistance and support. But, at the same time, those who oppose the legalization of physician assisted suicide must recognize that the move toward legalization is being driven by terminally ill patients themselves -- not by those who wish to discriminate against them. Terminally ill patients (and most of the rest of us who worry about how we will be treated should we, ourselves, become terminally ill⁶) wish to be protected from being denied medical care and support, but not at the cost of complete deprivation of the power to seek assistance in ending one's life in a dignified and humane fashion at a time when death becomes the preferable alternative. The challenge is to fashion laws which maximize the freedom to exercise the right while minimizing the risks of abuse.

Over the last twenty years, State lawmakers have admirably risen to this challenge. Concerned about the potential for abuse, they have quite wisely moved slowly and cautiously as they have gradually extended the rights of patients to choose death when that becomes preferable to continuing to endure the lives their illnesses force them to lead. By taking such small steps, State lawmakers have left themselves room to retreat if they found that the feared abuses had begun to occur. While some have decried this as movement down a "slippery slope," it seems to me to represent the ideal of cautious common law development by the courts and step-by-step statutory craftsmanship by the legislatures. Although I have not been happy with many details of the laws which have been produced and have frequently criticized them in print, the process of State lawmaking is one which has shown itself eminently open to correction and refinement. The Congress of the United States should not unnecessarily or unduly burden this process.

⁶ A poll conducted April 9-10, 1996, by the Gallup organization produced the results "Yes" (75%), "No" (22%) and "No Opinion" (3%) in answer to the question: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end a patient's life by some painless means if the patient and his family request it?"

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STATUTE

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

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Part I of this Article explains the relationship of physician-assisted suicide to the current law and to current thinking in medicine and philosophy. Part II explores the difficult choices that we made in determining what form of physician-assisted suicide should be available, who should be able to receive assistance, and how simultaneously to protect privacy and prevent abuse. Part III examines the constitutionality of our model statute. Finally, Part IV presents a detailed overview of the provisions of our statute.

1. THE MEDICAL, ETHICAL, AND LEGAL CONTEXT OF PHYSICIAN-ASSISTED SUICIDE

The statute that we propose is designed to provide the option of physician-assisted suicide to competent patients who either have a terminal illness or are suffering from unrelievable and unbearable distress, due to bodily illness, that is so great that they prefer death.⁶ The statute can be fully understood only in light of current medical, ethical, and legal constraints on physician-assisted suicide.

A. The Medical and Moral Basis for Physician-Assisted Suicide

We believe that it is reasonable to provide relief from suffering for patients who are dying or whose suffering is so severe that it is beyond their capacity to bear. Some opponents of physician-assisted suicide see such a step as a radical moral departure from present medical practice,⁷ but we believe it is consistent with the fundamental values underlying the legal and ethical requirements of respect for the right of competent patients to give or withhold their consent to any treatment, including life-sustaining treatment.⁸ The most basic values that support and guide all

health care decision making, including decisions about life-sustaining treatment, are the same values that provide the fundamental basis for physician-assisted suicide: promoting patients' well-being and respecting their self-determination or autonomy.⁹

The legal right to decide about life-sustaining treatment has given most patients appropriate control over their own dying, and we believe strongly that this control, along with proper supportive care, meticulous attention to details, and truly adequate pain relief measures, will meet the needs of the great majority of dying patients and usually obviate the occasion for the patient to consider the possibility of hastening death.¹⁰ However, for some patients who are undergoing severe suffering and confronting an unbearable or meaningless existence, either no life-sustaining treatment is available to be forgone or forgoing such treatment will result in a prolonged, unbearable, and inhuman dying process. Even when optimal care has been given, intolerable distress may remain in these patients, such that they may conclude rationally that hastening death is the only appropriate goal.¹¹ For these patients, more active means of hastening death are necessary, supported by the very same values that promote patients' well-being and respect their self-determination.

Viewed in this way, making physician-assisted suicide available to patients who choose it is not a radical departure in medical practice or public policy, but a natural and appropriate extension of presently accepted practices. Physicians are uniquely able to provide this necessary assistance with a combination of expert knowledge, compassionate concern for the patient, pro-

⁶ 2 (1989); DAN W. BAUER, *Death and Dying, in LIFE AND DEATH: PHILOSOPHICAL ESSAYS IN BIOETHICS* 144, 148-53 (1993).

⁷ See generally PATIENTS' CHOICE FOR THE STUDY OF ETHICAL PRIORITIES IN MEDICINE AND BIOETHICS: A COMMITTEE REPORT, MAKING DEATH CARE CHOICES (1992).

⁸ See, e.g., ANGELO, *The Quality of Mercy*, 306 NEW ENGL. J. MED. 98 (1992); CLELAND ET AL., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 NEW ENGL. J. MED. 592 (1994) (noting that many cancer patients receive inadequate pain treatment); MARICE M. THOMPSON ET AL., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69 (1987) (recognizing that treatment of pain remains a significant problem); ROBERT D. THOMPSON, *Analgesics in the Care of the Terminally Ill*, 327 NEW ENGL. J. MED. 1018 (1992) (noting common barriers to effective pain management).

⁹ THOMPSON ET AL., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69 (1987).

¹⁰ THOMPSON ET AL., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69 (1987).

¹¹ THOMPSON ET AL., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69 (1987).

¹² See, e.g., WILLARD (citing et al.), *Do Not Want Not Kill*, 259 JAMA 2119 (1988) (expressing assisted suicide as inconsistent with medical principles); LEON R. KASS, *Neither for Love nor Money: Why Do Not Want Not Kill*, PAIN 101 (1987).

¹³ See, e.g., CASS, *Neither for Love nor Money: Why Do Not Want Not Kill*, PAIN 101 (1987); HANCOCK & CHILDS, *Do Not Want Not Kill*, 319 N.E. 2d 240, 242 (Mass. 1982); THOMPSON ET AL., *Incidence and Characteristics of Pain in a Sample of Medical-Surgical Inpatients*, 30 PAIN 69 (1987).

professional responsibility to the patient and to society, and the ability to determine and prescribe the medication that the patient will usually require to achieve a humane and certain death.¹⁵ They should be able lawfully to provide the assistance necessary to achieve that goal. Our model statute would allow such assistance, while at the same time attempting to provide adequate protection against possible abuses.

B. Current Legal Obstacles to Physician-Assisted Suicide

In a jurisdiction without a statute authorizing physician-assisted suicide, a physician who provided means of suicide to a patient could be convicted of manslaughter¹⁶ or a specific crime of aiding or assisting a suicide or an attempted suicide.¹⁷ Under certain circumstances, such a physician could be convicted of murder, but in many states, a murder conviction requires active participation in the death rather than merely supplying the means of death.¹⁸ Nevertheless, even the possibility of murder charges is likely to have a deterrent effect on a physician who would otherwise consider assisting a patient to commit suicide. Indeed, even in a jurisdiction where assisted suicide is not prohibited by statute, a physician who assisted in a patient's suicide could be convicted of a common-law felony.¹⁹

Among the civil threats to physicians undertaking assisted suicide are liability for wrongful death²⁰ and medical malpractice.²¹ A physician might also face professional sanctions, either

¹⁵ See Ann Albers, & Bernard Fox, *Physician Assisted Suicide in Oregon: A Bold Experiment*, 224 JAMA 483 (1995), suggesting that the physician should be considered by physicians in light of legalization of physician-assisted suicide.

¹⁶ See, e.g., N.Y. Penal Law § 125.15(1) (1964-Kinney 1977) (Manslaughter); *People v. Kinney*, 527 N.W.2d 714, 738-39 (Mich. 1994), *cert. denied*, 115 S.Ct. 1795 (1995); *State v. Sexton*, 869 P.2d 301, 304 (N.M. Ct. App. 1994).

¹⁷ See, e.g., Minn. Penal Code § 210.52(1) (1962; N.Y. Penal Law § 120.30 (McKinney 1987)).

¹⁸ See, e.g., *People v. Cleaves*, 280 Cal. Rptr. 148, 151 (Cal. Ct. App. 1991); *People v. Kevorkian*, 527 N.W.2d 714, 738-39 (Mich. 1994), *cert. denied*, 115 S.Ct. 1795 (1995); *State v. Sexton*, 869 P.2d 301, 304 (N.M. Ct. App. 1994).

¹⁹ See, e.g., *Mass. Gen. L. ch. 27B, § 2* (1994), 42 Pa. Unsub. Stat. Ann. § 5401(a) (Supp. 1995).

²⁰ A physician can be found liable for malpractice when a patient commits suicide against the wishes of the physician. See, e.g., *Peoples Bank of Bloomington v. Darnett*, 581 N.E.2d 426, 429 (Ill. App. Ct. 1991); *Schakal v. Kania*, 471 N.E.2d 1111, 1115 (Mass. 1985); *Champlain v. United States*, 513 N.W.2d 75, 76-77 (N.D. 1994). By the same reasoning, a physician who actually *caused* a patient to commit suicide could be found liable.

as a result of specific ethical prohibitions on assisted suicide²² or because of the philosophical or political opposition of the reviewing disciplinary board. Finally, a physician who assisted in a suicide could lose staff privileges at a hospital that objected to the practice.

The net result of these obstacles to physician-assisted suicide is to deter physicians from considering the practice, even if they might otherwise have no objection to it.²³ As we explain in the next section, we believe that a statute is needed to enable physicians to assist patients in suicide in appropriate circumstances.

C. The Need for a Specific Statute

Laws that deprive persons of access to physician-assisted suicide have been challenged recently on constitutional grounds in federal and state courts in several jurisdictions.²⁴ We feel that a preferable way to establish a right to physician-assisted suicide is to make this option available to persons through explicit statutory authorization. Even if laws restricting assisted suicide are struck down, laws or regulations will be necessary to provide oversight and protection against abuse.²⁵ Our statutory approach permits the careful development of procedures necessary to limit abuse. A statute also more clearly requires and establishes the public support that should exist for the practice before it is made legally available.

²² See Chris G. Menikoff, *supra* note 1, § 2.2.1 ("Physician-assisted suicide is fundamentally incompatible with the physician's role as healer"). The Hippocratic Oath prohibits direct assistance in death. See, e.g., *Am. Med. Ass'n v. U.S. Dep. of Health & H.S. Servs.*, 702 F.2d 1163, 1167 (9th Cir. 1983), *cert. denied*, 469 U.S. 1151 (1984).

²³ See Shapiro et al., *supra* note 5, at 581 (noting that although 35.2% of physicians responding had been asked to perform euthanasia and 27.8% would be willing to perform euthanasia if it were legal, only 2.2% had actually performed it).

²⁴ See *Compassion in Dying v. Washington*, 49 F.3d 586, 598 (9th Cir.), *reh'g en banc granted*, 62 F.3d 299 (9th Cir. 1995); *Quill v. Vopek*, 870 F. Supp. 78 (S.D.N.Y. 1994); *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S.Ct. 1795 (1995). See generally Yale Kamisar, *Are Laws Against Assisted Suicide Constitutional?*, 11 Hastings Const. L.J. 417, May/June 1993, at 32 (arguing against a right to assisted suicide).

²⁵ See Guy F. Herbig, *Euthanasia: The Need for Professional Safeguards*, 326 N.W.2d 100, 107 (1992); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 131 N.W.2d 100, 111 (1994); Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 N.W.2d 100, 100 (1992).

Commentators have argued that there is no need for legislation in states where assisted suicide is not specifically outlawed by statute, because physicians in those states may legally provide patients with means of suicide or, in any event, need not fear prosecution for doing so.²⁶ Others have maintained that to legalize physician-assisted suicide would make suicide "too easy," opening the option to patients whose conditions do not warrant such an extreme measure and risking that it would be urged on patients who do not want it.²⁷ Some contend that legislation would impose onerous regulations on the conduct of a procedure that already takes place when, in the judgment of the physician, the situation warrants it.²⁸

On the contrary, for the following reasons, we believe that society and the medical profession would be better served by a statute that expressly permits physician-assisted suicide under certain well-defined circumstances, rather than by no law at all: First, in states that do not explicitly prohibit any form of assisted suicide, the law's silence leaves physicians in serious doubt concerning the legality of providing means of suicide to a patient,²⁹ while in states that do outlaw assisted suicide, physicians must risk prosecution for a felony in order to assist in a patient's suicide.³⁰ As a result, patients who seek means of dying are often denied assistance,³¹ and success in finding a physician who will help may be a result of luck more than of need.

Second, physicians who now provide assistance in suicide may be compelled by fear of prosecution to do so in secret,³² without the opportunity to discuss the case fully and freely with colleagues or other professionals. In contrast, physicians have ac-

²⁶ See, e.g., Leonard H. Glantz, *Withholding and Withdrawing Treatment: The Role of the Criminal Laws*, 15 *Law, Medicine & Ethics* 326, 331-332 (1987) (1988) ("No physician has been charged with a crime for assisting a patient to die, and no physician has been held civilly responsible for an act of either conviction or acquittal that led to the death of a seriously ill patient"); As noted above, however, the lack of a statute prohibiting physician-assisted suicide does not preclude prosecution. See *supra* note 19 and accompanying text.

²⁷ See, e.g., George J. Annas, *Death by Prescription: The Oregon Initiative*, 31 *N.Y.U. L. Rev.* 1240, 1243 (1994) (noting risks to pass, elderly, and minorities); J. David Wilkinson, *Against the Right to Die*, 17 *J. Med. & Phil.* 605 (1992) (recognizing danger of coercion).

²⁸ See, e.g., *supra* note 21, at 1242-43.

²⁹ See *supra* note 19 and accompanying text.

³⁰ See *supra* note 19 and accompanying text.

³¹ See, e.g., *supra* note 19, at 1242-43.

³² See, e.g., *supra* note 19, at 1242-43.

cess to a variety of professional consultations, often including review by ethics committees or consultants, in connection with other profoundly serious medical-ethical decisions.³³

Third, physicians who now provide assistance in suicide do so without any form of accountability, procedures, requirements, or guidelines to assure that the patient's request for assistance is competent, fully informed, voluntary, and enduring and that the diagnosis and treatment options have been confirmed and fully explained to the patient.

Fourth, in the absence of assistance from a physician, many terminally ill patients now attempt to end their lives on their own, often in ignorance of and without access to the best means of doing so.³⁴

Fifth, some terminally ill patients prematurely elect to end their lives by foregoing treatment because they fear that the opportunity to end their lives will not arise later should their suffering become unendurable.³⁵

Finally, with or without assistance from a physician, many patients who end their lives may feel obliged to do so in solitude, without the professional advice of a physician or the presence and comfort of loved ones.

II. THREE FUNDAMENTAL ISSUES

A. Active Euthanasia Versus Physician-Assisted Suicide

Our proposed statute would legalize physician-assisted suicide under certain conditions, but it does not address voluntary active euthanasia. By "physician-assisted suicide," we mean providing

³³ See Troyen A. Brennan, *Ethics Committees and Decisions to Limit Care: The Experience at the Massachusetts General Hospital*, 260 *JAMA* 903 (1988); John LaParo et al., *An Ethics Consultation Service in a Teaching Hospital: Initiation and Evaluation*, 260 *JAMA* 818 (1988). See generally, J. David Wilkinson, *Ethics Committees and Active Euthanasia: Decision Making Without Boundaries*, 1 *Health Care Decision Making* 10 (1991).

³⁴ See, e.g., *supra* note 19, at 1242-43 (reporting several disastrous suicide attempts); *supra* note 31, at 45-55 (telling story of a bungled suicide attempt); July B. Gabel, *Relief from Terminal Suffering*, 160 *Ida.* 93 (1994) (discussing a nearly botched suicide attempt); *supra* note 31, at 45-55 (telling story of a bungled suicide attempt).

³⁵ See, e.g., *supra* note 19, at 1242-43 (reporting several disastrous suicide attempts); *supra* note 31, at 45-55 (telling story of a bungled suicide attempt); July B. Gabel, *Relief from Terminal Suffering*, 160 *Ida.* 93 (1994) (discussing a nearly botched suicide attempt); *supra* note 31, at 45-55 (telling story of a bungled suicide attempt).

the patient with the means, such as a drug that can be lethal in certain doses, to end his or her own life. Voluntary active euthanasia, in contrast, requires the active participation of the physician in performing the action, such as administering a lethal injection, that ends the patient's life. Members of the public and the medical community disagree, and we disagree among ourselves, as to whether there is an important difference between the two concepts.¹⁶

We have chosen to allow only physician-assisted suicide for two main reasons. First, we consider the voluntariness of the patient's act to be critical. Restricting the statute to physician-assisted suicide provides in many cases a stronger assurance of the patient's voluntary resolve to die and of the central role of patient responsibility for the act. Second, we believe that there would be greater acceptance of the model statute by the public, legislators, and physicians if it were limited to physician-assisted suicide, partly because of the public perception of voluntariness and partly because of the strong ethical objections of some physicians and others to euthanasia.¹⁷

B. Which Patients Should be Eligible for Physician-Assisted Suicide?

We agreed from the outset that to be eligible for physician-assisted suicide, the patient must be an adult, aged eighteen years or older.¹⁸ We also agreed that anyone who is terminally ill, that is, likely to die from an illness within six months, should qualify without having to demonstrate that his or her suffering is unbearable.¹⁹ We continued to debate until the very end of our

deliberations as to how far, if at all, to broaden this eligibility beyond the six-month limit. Our major concern was whether and how to extend the option to patients who are not likely to die from their illnesses within six months but have bodily disorders that cause intractable and unbearable suffering, such as AIDS, advanced emphysema, some forms of cancer, amyotrophic lateral sclerosis, multiple sclerosis, and many other debilitating conditions.

With respect to this issue, we faced the difficulty of defining unbearable suffering in a sufficiently objective fashion that physician-assisted suicide would not be available to everyone who had some form of physical or psychological suffering and merely requested it. In the end, a bare majority of us agreed to allow anyone to be eligible whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death.²⁰ We rejected a more objective definition of the patient's suffering for two principal reasons. First, we found that it was not possible to construct an objective definition that was not overly restrictive as to the patients who would meet it. Second, and more important, we realized that whether one's suffering is sufficiently unbearable to make death preferable to continued life is an inherently subjective determination on which people differ, and for which no objective standard should be imposed on everyone. Because the statute does not endow the patient with a right to physician-assisted suicide, however, the physician still retains the ability to decide whether the case warrants providing such relief. In addition, because the statute requires competency,²¹ the subjective preference for death of a clinically depressed or mentally ill patient would be insufficient to qualify that patient for assisted suicide.

¹⁶ Langford, *supra* note 4, at 106; E. Meert, *Physician Assisted Dying: Theory and Reality*, 1 J. Clinical Ethics 35, 35 (1992) (arguing that the line between passive and active euthanasia is blurred, *supra* note 4, at 186 (a psychological, but not an ethical, difference); and Brock, *Voluntary Active Euthanasia*, *supra* note 4, at 10 (no significant difference).

¹⁷ See *supra* note 10 and accompanying text.

¹⁸ See Model Act § 3(a)(1).

¹⁹ See *supra* note 10 and accompanying text. Patients with terminal illnesses have generally been seen as the least controversial candidates for the recognition of a right to die. Early decisions in this regard began by recognizing the right of such patients to refuse life prolonging treatment. See, e.g., *Quinlan*, 40 N.J. 10 (1976) (recognizing the right of a terminally ill patient to refuse treatment only to those with terminal illnesses); *Glendon G. Smith v. State of New Jersey*, 103 N.J. 120, 417 (1985) (1977). Likewise, early legislation restricted the right to physician-assisted suicide to those with terminal illnesses. See, e.g., *Uniform Gifts to Minors Act*, sec. 1, § 7187(c) (1), 1976 Cal. Stat. 6478, 6479 (repealed 1991). The fact that terminal patients will die soon, with or without treatment, may be seen as reducing the strength of any countervailing state interest in preventing such patients from deciding to shorten their lives further and as reducing the cost of any crisis that may

be made in the process of the decision to refuse treatment. The physical and psychological pain suffered by a terminally ill patient also suggests that his or her desire to hasten death may be reasonable. Finally, the restriction of the right to the terminally ill establishes a boundary that helps to address slippery-slope concerns. See *infra* text *accompanying* note 22.

²¹ See Model Act § 2(d).

Procedural safeguards that adequately protect both patients and physicians unavoidably conflict with the privacy of patients and families and the privacy of the physician-patient relationship. To maximize privacy, we considered proposing a statute that would simply state in very general terms that physician-assisted suicide was legal under certain stated factual circumstances but would not prescribe procedural requirements. Under this abbreviated approach, an assisted-suicide statute might comprise only a few simple provisions to the effect that a physician would not be guilty of unlawfully assisting a patient to commit suicide, provided that: (1) the physician's assistance were limited to making available a substance used by the patient to end the patient's life; (2) the patient had an illness that was either terminal or caused the patient intractable and unbearable suffering; (3) the patient had made a decision to hasten death because of the illness; and (4) the patient's decision was fully informed as to relevant medical facts and was not the result of a mental illness or undue influence from other persons. We concluded that such an abbreviated approach would not adequately protect patients or physicians.

The procedures, conditions, and documentation requirements built into the model statute are designed to ensure that physician-assisted suicide is restricted to patients who are truly terminally ill or suffering from intractable and unbearable illnesses, and whose requests are demonstrably competent, fully informed, voluntary, and enduring. To govern the practice in accordance with these principles, it is necessary that the statute contain strong safeguards and precise procedural requirements. Such detailed requirements will counter a common objection to making physician-assisted suicide legally permissible: the so-called "slippery slope" argument.⁴⁷ While it is not possible to guarantee that abuse and unjustified extension of the practice cannot or will not take place, we believe strong and effective safeguards, together with a clear understanding of the rationale for the practice and

the limits to which it applies, can reasonably meet concerns about a slippery slope.⁴⁸

From the physician's perspective, an abbreviated approach such as that described above would preserve the physician's autonomy, would avoid imposing burdensome regulations on the physician, and would not intrude into the physician-patient relationship. It would not, however, adequately protect physicians and could make them unwilling to provide assistance in suicide even in appropriate situations. Because the conditions under which physicians could legally assist patients in suicide would be stated so generally, physicians would not know in advance whether a particular case fit those conditions and what actions they should take to obviate any significant risk of criminal charges. Even if a physician acted on a good-faith belief that the statutory conditions were met, he or she might be vulnerable to legal charges later. This possibility would almost certainly leave many physicians, who might have no principled objection to physician-assisted suicide, reluctant to provide it to any of their patients who might request it.⁴⁹

Thus, not only for the protection of patients, but also for the protection of physicians, we chose to outline specific requirements that, when followed, offer the physician legal protection. Moreover, we concluded that extensive safeguards would both protect the integrity of the medical profession and help ensure that public trust in that integrity remains warranted.⁵⁰ If the public is to ask the medical profession to participate in physician-assisted suicide, then strong safeguards are a reasonable cost for the public and patients to bear.

It would be a mistake, however, to think that procedural safeguards do not come at a significant cost to the patient and to the physician-patient relationship. At what will typically be an emotionally difficult time for the patient and family, unfamiliar third-party consultants, evaluators, and witnesses must intrude into the physician-patient relationship. Patients and their families will often quite reasonably view the procedures as a profound inva-

⁴⁷ Cf. Margaret Martin, *Voluntary Euthanasia and the Risk of Abuse: Can We Learn Anything from the Netherlands?*, 20 J. AM. MED. ASSOC. 1461 (1997) (advocating that the Netherlands' law be amended by requiring a second independent physician's approval in order to prevent abuse); and this report's recommendation that the Netherlands' law be amended to require a second independent physician's approval in order to prevent abuse. See also note 23 and accompanying text.

⁴⁸ See Gaylin et al., *supra* note 10, at 2139-40; David Drelich, *Physician Assisted Suicide in Assisted Suicide*, 262 JAMA 1843 (1989).

⁴⁹ See, e.g., Daniel Callahan, *When Aid Becomes Harm*, HASTINGS CTR. REP., Mar-Apr 1992, at 33; Callahan, *supra* note 10, at 2140-41; Peter A. Ruse, *Barriers to Euthanasia: A Critique*, 32 N.W. L.W. 3 (Mar. 1981), 108 A (1980). See generally, *When van der Burg, The Slippery Slope Argument*, 102 LEXIS 32 (1991) (reaffirming various terms of the argument).

sion of their privacy at a point when time is short and privacy is especially important. We feel, nevertheless, that such procedures are necessary in order to ensure that in less-than-ideal relationships and conditions, misuse or abuse of the practice of physician-assisted suicide does not occur.

The detailed procedures also provide an openness to the practice of physician-assisted suicide that can give society greater assurance that the practice is operating as intended, and can provide feedback to government and professional bodies about needed refinements and revisions in the practice over time. In our final formulation of the statute, we therefore leaned in the direction of more extensive and comprehensive safeguards, acknowledging the costs to some patients and physicians.

III. CONSTITUTIONALITY OF THE MODEL ACT: *LEE V. OREGON*

In November 1994, Oregon voters enacted by initiative the nation's first statute explicitly permitting and regulating physician-assisted suicide.⁴⁵ The Oregon Act, which is similar in a number of respects to our proposed statute,⁴⁷ was promptly challenged in federal court on grounds that it violated the Fourteenth Amendment to the United States Constitution. On August 3, 1995, in *Lee v. Oregon*,⁴⁸ District Judge Michael R. Hogan declared the statute unconstitutional under the Equal Protection Clause of the Fourteenth Amendment.⁴⁹ The case is now on appeal to the United States Court of Appeals for the Ninth Circuit.⁵⁰

We believe that the *Lee* case was wrongly decided and that our proposed statute will withstand appropriate constitutional scrutiny.

In 1990, the Supreme Court of the United States rendered its only decision to date on the subject of the right to die. In *Cruzan v. Director, Missouri Department of Health*,⁵¹ the Court held that, where an incompetent patient is involved, a state may constitutionally require "clear and convincing" proof that the patient

would want life-prolonging treatment withdrawn.⁵² In passing, the Court recognized a patient's "constitutionally protected liberty interest" in refusing unwanted medical treatment.⁵³ Four Justices believed this liberty interest to be so strong in the context of a patient in a persistent vegetative state that they would have held the Missouri law restricting it unconstitutional under the Due Process Clause of the Fourteenth Amendment.⁵⁴ The other Justices, with the exception of Justice Scalia, also recognized such a constitutionally based right.⁵⁵ But they recognized as well a strong interest of the state in protecting the autonomy of an incompetent patient,⁵⁶ and they held that a state could constitutionally advance its interests, if it chose to do so, by requiring clear and convincing evidence of the patient's wishes.⁵⁷ Judge Hogan's opinion in *Lee* turned *Cruzan* on its head. Whereas *Cruzan* dealt with state legislation that restricted a patient's right to be free from unwanted treatment, *Lee* dealt with state legislation advancing that right. Whereas *Cruzan* protected the right of the legislature to regulate the details of practice in this developing area, even though the regulation impinged upon a protected liberty interest, *Lee* struck down a popularly mandated measure that advanced that liberty interest.

The fault in the Oregon Act, from Judge Hogan's point of view, was that it did not advance patients' liberty interests as rationally as it might. In particular, the *Lee* court was concerned that (1) the Oregon Act permits "physicians who may not be psychiatrists, psychologists, or counselors to make an evaluation whether a condition is causing [the patient to exercise] impaired judgment";⁵⁸ (2) "there is no requirement that [the patient] consult a certified social worker or other specialist to explore social services which might assist the person to live in greater comfort";⁵⁹ and (3) these and other failures in protection of the rights of patients apply only to the "terminally ill."⁶⁰ The court's sug-

⁴⁵Id. at 278.

⁴⁶Id. at 278.

⁴⁷See id. at 316 (Herman, J., dissenting, joined by Marshall and Blackman, JJ.); id. at 350-51 (Stevens, J., dissenting).

⁴⁸See id. at 218-79 (Hogan, J., for the Court); id. at 287 (O'Connor, J., concurring); id. at 299-300 (Scalia, J., concurring [arguing that case does not implicate Constitution]).

⁴⁹Id. at 281-82.

⁵⁰Id. at 284-85.

⁵¹See, 801 F. Supp. at 1415.

⁵²Id.

⁵³Id. at 1417.

⁵⁴Oregon Death With Dignity Act, 1995 Or. Laws ch. 3 (hereinafter Oregon Act).

⁵⁵In the interest of disclosure, we feel that we should mention that one of us played a minor role in the drafting of the Oregon Act.

⁵⁶801 F. Supp. 1429 (D. Or. 1995).

⁵⁷Id. at 1419.

⁵⁸Id. at 1419.

⁵⁹Id. at 1419.

⁶⁰See, e.g., *Blackwood*, *supra* note 47, No. 95-15004 (9th Cir. Aug. 11, 1995).

⁶¹397 U.S. 261 (1970).

gestion was that somehow the Oregon Act discriminated against the terminally ill as a class in violation of the Equal Protection Clause. Yet in the case of the Oregon Act and other legislation classifying patients on the basis of terminal illness, it is those persons who fear that they will one day find themselves among the terminally ill who are urging the enactment of such legislation to protect themselves from a lingering, undignified death. Clearly invidious motives are not at work when such statutes use terminal illness as a basis for classification.

Because the Oregon Act does not impinge upon a fundamental right and does not establish a classification on a basis that raises suspicions of invidious discrimination, the court was required to review the measure under the most lenient of constitutional standards.⁶¹ It could find the Oregon Act unconstitutional only if one could conceive of no rational basis upon which the state could have used the means employed to advance a legitimate state interest.⁶² In fact, Judge Hogan appears to have applied his own version of rational review and struck down the Oregon Act because it was not as rational as he thought it should have been. This sort of constitutional review is reminiscent of the discredited doctrine of *Lacher v. New York*.⁶³ A proper application of the rational-basis test would find both the Oregon Act and the statute that we propose here to be constitutional under the Fourteenth Amendment.

While we believe *Lee* will be reversed by the Ninth Circuit, we should note that our proposed statute addresses several of what Judge Hogan perceived to be the shortcomings of the Oregon Act. Our statute provides for a review of the patient's competency by a licensed psychiatrist, clinical psychologist, or psychiatric social worker;⁶⁴ allows patients the opportunity to consult with a social worker about alternatives to suicide;⁶⁵ and relieves to relieve physicians from liability for such actions as a negligent diagnosis.⁶⁶

⁶¹ See *Schwabach v. Wilson*, 430 U.S. 221, 230 (1977).

⁶² See *id.*, 137 U.S. 133 (1901).

⁶³ 108 U.S. 45 (1903).

⁶⁴ See Model Act § 3(b).

⁶⁵ See *id.* § 4(b).

⁶⁶ See *id.* § 1(b).

IV. OVERVIEW OF THE MODEL ACT

A. Who May Provide Physician-Assisted Suicide?

The model statute allows a "responsible physician" to practice physician-assisted suicide and places a series of responsibilities on that physician.⁶⁷ The first question that we faced was who should be allowed to assume that role. Ideally, the physician who assists in a patient's suicide will be the one who has managed the patient's illness and who has a close professional relationship with the patient. However, the statute recognizes that because ethical constraints may prevent some physicians from assisting in suicide, a patient may need to have another physician provide him or her with the means of suicide. Section 2(h) therefore allows any physician who has assumed full or partial responsibility for a patient's care to assume the role of responsible physician, even though he or she is not the patient's primary physician.

B. Other Definitions

Section 2(e) defines "medical means of suicide" as a medical substance or device prescribed for or supplied to a patient by the responsible physician. The use of the term "medical" requires that the means of suicide be otherwise consistent with sound medical practice; thus, providing a patient with an unapproved drug or a firearm (to take an extreme example) would not be permissible.

The definitions of "intractable and unbearable illness" and "terminal illness" are discussed above.⁶⁸ The remaining definitions in section 2 are self-explanatory.

C. Conditions to be Met Before a Patient Receives Assistance in Suicide

A fundamental goal of the statute is to protect patients from coercion or premature judgment. Section 3(a)(3) thus requires

⁶⁷ See § 4(b).

⁶⁸ All further references in the text of this Article to "section" are references to sections of the Model Act unless otherwise specified.

⁶⁹ See *supra* part II.B.

that four basic conditions be met before a physician may grant a patient's request for assisted suicide: the request must be competent, fully informed, voluntary, and enduring. The first three requirements are similar to those required for informed consent to ordinary medical treatment;⁷⁰ and the fourth is designed to ensure the consistent resolve of the patient. However, because of the seriousness and finality of the patient's decision, the requirements of the statute exceed those of consent to ordinary treatment.⁷¹

A competent request within the meaning of section 3(a)(3)(A) is a reasoned request for physician-assisted suicide from a patient, based on the patient's ability to understand his or her condition and prognosis, the benefits and burdens of available alternative treatments, and the consequences of suicide. A request distorted by clinical depression or other mental illness or impairment is not competent. However, the statute does not prohibit physician-assisted suicide for a patient suffering from clinical depression if the patient's judgment is not distorted—in other words, if the patient can make a reasoned decision consistent with his or her long-term values. A terminal illness is inherently depressing, and denying a patient assistance in suicide only because he or she feels sad or depressed would not be proper.⁷² Nevertheless, the statute mandates that a professional mental health care provider evaluate the patient to determine that his or her decision is fully informed, free of undue influence, and not distorted by depression or any other form of mental illness.⁷³

A fully informed request within the meaning of section 3(a)(3)(B) means that the patient understands the medical options available and their consequences. Section 4 requires the physician to dis-

⁷⁰ See *Canterbury v. Spence*, 464 F.2d 772, 782-89 (D.C. Cir.), cert. denied, 409 U.S. 1084 (1972); *Cobbs v. Grant*, 502 P.2d 1, 10-11 (Cal. 1972); *Harnish v. Children's Hosp. Medical Ctr.*, 430 N.E.2d 240, 241-44 (Mass. 1982).

⁷¹ Individuals who are not competent to make legally required consultations with respect to diagnosis or competency, witnessing of the informed consent discussion, to documentation with the specificity required by our statute (compare cases cited *supra* note 70 with Model Act §§ 40b, 5).

⁷² See Linda F. Hanzini et al., *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 *Am. J. Psychiatry* 1611 (1994) (finding that in study of mild to moderate depression, remission of depression did not alter patients' desire for life-sustaining therapy); Melinda A. Lee, *Depression and Relief of Life Support in Older People: An Ethical Dilemma*, 10 *J. Am. Geriatrics Soc.* 710, 712 (1990) ("When suffering is unlikely to abate, a decision [by a depressed patient] that death is preferable to life may not necessarily be unwise...").

⁷³ Model Act § 5(b).

cuss all medical treatments that might improve the patient's condition or prognosis that are practicably available, including treatment for pain, and their benefits and burdens; to offer the patient the opportunity to consult with social workers about social services that may improve his or her condition; and to advise the patient of the options for ending his or her life and their benefits and burdens. For a request to be fully informed, the patient must understand all of this information and make a reasoned decision to seek suicide. Section 3(a)(3)(B) is intended to ensure active decisionmaking by the patient; passive acquiescence in the recommendations of others would not constitute a fully informed and reasoned decision.

Section 3(a)(3)(C) requires that the patient's request be voluntary, meaning that it is made independently, free from coercion or undue influence. The patient may consider the suggestions and recommendations of others, including the responsible physician, but the patient's choice must be his or her own decision.⁷⁴

Finally, section 3(a)(3)(D) requires that the patient's request be enduring. Ideally, the patient will have discussed physician-assisted suicide with a number of individuals on multiple occasions. At a minimum, however, the request must be stated to the responsible physician on at least two occasions that are at least two weeks apart, without self-contradiction during that interval. The two-week period is an attempt to balance the prevention of hasty decisionmaking against the prolonging of unbearable suffering.

Section 3(a) places the responsibility on the responsible physician to ensure that all of its requirements are met. In order to provide the physician with considerable advance assurance that he or she can avoid litigation attempting to second-guess his or her determinations,⁷⁵ the statute makes the physician's standard entirely subjective: the physician need have only an "honest belief" that the elements of section 3(a) have been met in the particular case. However, to compensate for the lack of any

⁷⁴ Cf. *Restatement (Second) of Contracts* § 336(1) (1981) ("Undue influence is unfair persuasion of a party who is under the domination of the person exercising the persuasion or who by virtue of the relation between them is justified in assuming that person will not act in a manner inconsistent with his welfare"; *Marath v. Stickle*, 386 S.W.2d 321, 341 (Mo. Ct. App. 1965) (holding that undue influence in probate cases is based on the exercise of the power of influence of the person making the will)).

⁷⁵ See *supra* text accompanying note 44.

requirement of reasonableness, the responsible physician enjoys the protection conferred by the statute only if he or she also satisfies the procedural requirements of sections 4, 5, and 6,¹⁶ which are designed to produce and preserve independent corroboration that the physician's belief is not merely honest or reasonable, but accurate. If the responsible physician materially complies with these requirements¹⁷ and there is no proof that he or she lacked the requisite honest belief, he or she is protected from liability for assisting in a suicide.¹⁸ As discussed below,¹⁹ however, the responsible physician and other participants are not relieved of any liability that they may otherwise incur as a result of any malpractice that they commit in the process of assisting in a suicide.

D. Procedures to be Followed Before and After a Patient Receives Assistance in Suicide

Section 4 outlines the information that the responsible physician must present to the patient in order to ensure that the patient's decision is fully informed and reexamined. Section 4(a) requires the responsible physician to offer the patient any medical care that may cure or palliate the illness or relieve its symptoms. Hospice care must be offered if available, but treatments that are inconsistent with accepted medical practice or impracticable need not be.²⁰ Section 4(b) requires the responsible physician to make a social worker available to the patient to discuss non-medical options that might change the patient's decision to seek suicide.

¹⁶ See Model Act § 3(a).

¹⁷ Cf. 2 E. ALAN FARNSWORTH, *FARNSWORTH ON CONTRACTS* § 8.16 (1990) (discussing material breach and substantial performance in contract law).

¹⁸ See Model Act § 4(b).

¹⁹ See Model Act § 4(c).

²⁰ Sometimes treatments or other services will be impracticable because the patient lacks the resources or health insurance necessary to pay for them. Such a situation prevents health care providers and patients with a painful ethical dilemma (on the one hand, it seems plainly wrong for a patient to be forced to consider suicide because of a lack of ability to obtain treatments or services that might mitigate his or her condition or circumstances. On the other hand, if there is no way to right this wrong in a particular situation, it seems doubly wrong to deny the patient access to assisted suicide that he or she has requested. We believe that the physician has a moral obligation to provide appropriate health care and other services to all its citizens, it cannot justifiably deny individuals relief from conditions that they find all the more intolerable because of society's moral failure.

The responsible physician must suggest to the patient under section 4(c) that he or she consult family members about the decision to request assistance in suicide, but the patient need not do so. Although mandatory family notification has been upheld against constitutional challenges in similarly sensitive situations,²¹ we believe that competent, adult patients should not be required to notify family members of their intended suicide against their will. The items required to be discussed by section 4(d) have been mentioned previously,²² but that section also requires a recorded or documented account of the discussion with two witnesses who are entitled to question the responsible physician and the patient.

Section 5 contains the corroboration requirements. Section 5(a) requires a second medical opinion as to the patient's diagnosis and prognosis, while section 5(b) requires a combination medical-factual opinion as to the patient's qualifications for physician-assisted suicide under section 3(a)(3). Broadly worded, unsupported opinions should be insufficient to enable the responsible physician to proceed; instead, each opinion should evidence a thorough investigation and demonstrate that the patient meets the statutory standards. An opinion that conflicts with the responsible physician's opinion should prevent the responsible physician from proceeding with an assisted suicide, at least until circumstances change substantially and a consultant then agrees with the responsible physician's opinion.

Finally, section 6 requires the responsible physician to document promptly the provision of medical means of suicide to a patient, both in the patient's records and with the state's regulatory authority.

E. Presence at the Patient's Death

Ending one's life in solitude can be a lonely and frightening undertaking, fraught with uncertainty, ambivalence, and opportunities for failure. We hope that the responsible physician will be present at the patient's death in order to reassure the patient and to make certain that the process is carried out effectively. Section 3(b) allows, but does not require, the physician to be

²¹ Cf. *Planned Parenthood of Southeastern Pa. v. Casey*, 112 S. Ct. 2791, 2812 (1992) (upholding requirement of parental notification before minor obtains abortion).

²² See supra part IV c.

present if the patient so desires, and section 7(a) also allows the presence of any other persons selected by the patient. Each section requires only that the final physical act of administering the means of suicide be the knowing, intentional, and voluntary act of the patient.

E. Monitoring and Enforcement

The submission of reports by responsible physicians allows the state Department of Public Health (or a similar regulatory agency) to collect the data (specified in section 8(a)) necessary to improve the statute's operation and to make the annual public report of its effectiveness required by section 9(d). For purposes of tracking the operation of the statute, it would be desirable to determine how often and under what circumstances medical means of suicide were actually used by patients to end their lives. However, because the responsible physician need not be present at the patient's death, and because the physician who signs the death certificate may not be the same physician who provided the deceased with the means of suicide, there appears to be no way of accurately determining the extent to which medical means of suicide are actually used.

A physician's report must not include the patient's name for reasons of privacy, but section 8(b) requires a coded link between the report and the patient's name, which may be used if legal or ethical questions should arise after the patient's death.

Section 9 requires the agency to monitor and enforce the requirements of the statute and grants the agency rulemaking authority. The statute proceeds on the assumption that it is impossible in such a complex field to deal in advance with all possible problems by a legislative act. We believe that a reasonable solution is to enact the legislation and then to provide an administrative body with the power to respond to new patterns of problems through the regulatory rulemaking process.

G. Confidentiality, Conscientious Objection, and Discrimination

To protect the privacy and confidentiality of everyone involved in a particular physician-assisted suicide, section 10(a) declares that any information about a patient must be kept confidential.

Section 10(b) further specifies that a responsible physician's report on file with the regulatory agency is also confidential and is not subject to the customary state statutes regarding public records.

Section 11 protects the decisions of physicians, hospital employees, and hospitals themselves to refuse to participate in physician-assisted suicide on grounds of conscience. A hospital or other institution may forbid physician-assisted suicide on its premises or within its jurisdiction if the institution notifies its staff in advance of the policy.

Finally, section 12 protects patients from discrimination by physicians, institutions, and insurers. No health care provider or insurer is permitted to require any patient to request physician-assisted suicide as a condition of eligibility for services, benefits, or insurance. At the same time, section 12 protects patients from discrimination (including the voiding of life insurance policies) because they have chosen to pursue assisted suicide. Unless physicians, institutions, and insurers opt out for reasons of conscience under section 11, they must honor patients' choices to seek or avoid assistance in suicide.

H. Liability and Sanctions

Section 13 protects those who participate in physician-assisted suicide from the types of liabilities identified in Part I.B. of this Article. The protection of section 13(a), however, is limited to the mere fact that a person has participated in an assisted suicide; he or she may not be convicted of homicide, for example, solely on the basis that he or she provided deadly drugs to a patient who committed suicide. On the other hand, section 13(c) notes that the statute does not limit the civil or criminal liability of any person for intentional or negligent actions merely because those actions were part of a physician-assisted suicide. Thus if a responsible physician or consulting physician commits malpractice by erroneously diagnosing a patient's condition, he or she is liable for the damages caused by that malpractice. The responsible physician is not, however, stripped of protection against liability for assisting in a suicide per se unless he or she has failed to meet the requirements of one or more sections of the statute.¹¹

¹¹ See Model Act § 13(a).

Section 14 declares that a willful violation of a provision of section 3, 4, 5, 6, or 7 is a crime (the precise grade of the crime is left to the individual state). Whether an action results in the death of a patient or not is immaterial. Of course, a violation of one of these provisions may also render a person liable under another provision of law; for example, a responsible physician who does not comply in all material respects with sections 4, 5, and 6 does not enjoy the protection from liability for assisting in a suicide that section 13 otherwise affords. In appropriate cases, section 14 provides a prosecutor with a method for enforcing the statute that falls short of a prosecution for homicide or assisting in a suicide.

As for other wrongful acts, such as coercing a person to request or use medical means of suicide, section 13(c) leaves the definition of offenses and the imposition of sanctions to existing law.

V. CONCLUSION

Physician-assisted suicide has become a subject of increasingly widespread and intense public and professional debate. A growing array of efforts is also underway to make physician-assisted suicide available under the law. As noted in Part III, Oregon recently adopted legislation to allow physician-assisted suicide. Constitutional challenges to laws prohibiting assisted suicide in Washington, Michigan, and New York have recently wound their way through the courts.³⁴ Legislation to permit physician-assisted suicide has been introduced recently in a number of state legislatures.³⁵ As these efforts approach fruition, it becomes increasingly important that debates about physician-assisted suicide address concrete issues of morality and policy design. Supporters of physician-assisted suicide have a special responsibility to propose specific, detailed proposals for a well-regulated and suitably circumscribed practice. We intend the statute presented below to help meet that responsibility.

³⁴ See *supra* note 24.

³⁵ See, e.g., Cal. A.B. 1080, 1995-96 Reg. Sess., Cal. H.B. 1100, 100th Gen. Ass., 1st Reg. Sess. (1995); Mass. H.B. 1171, 170th Gen. Ct., 1st Ann. Sess. (1995); N.H. H.B. 110, 1995 Reg. Sess.; N.Y. S.B. 1681, 210th Gen. Ass., 1st Reg. Sess. (1995); Wis. A.B. 171, 92d Leg. Sess., 1995-96 Reg. Sess.

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

SECTION 1. STATEMENT OF PURPOSE

The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness or from a bodily illness that is intractable and unbearable. Its further purposes are (a) to ensure that the request for such assistance is complied with only when it is fully informed, reasoned, free of undue influence from any person, and not the result of a distortion of judgment due to clinical depression or any other mental illness, and (b) to establish mechanisms for countering oversight and regulation of the process for providing such assistance. The provisions of this Act should be liberally construed to further these purposes.

SECTION 2. DEFINITIONS

As used in this Act,

- (a) "Commissioner" means the Commissioner of the Department.
- (b) "Department" means the Department of Public Health or similar state agency.
- (c) "Health care facility" means a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States.
- (d) "Intractable and unbearable illness" means a bodily disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.
- (e) "Medical means of suicide" means medical substances or devices that the responsible physician prescribes for or

supplies to a patient for the purpose of enabling the patient to end his or her own life. "Providing medical means of suicide" includes providing a prescription therefor.

(f) "Patient's medical record" means (1) in the case of a patient who is in a health care facility, the record of the patient's medical care that such facility is required by law or professional standards to compile and maintain, and (2) in the case of a patient who is not in such a facility, the record of the patient's medical care that the responsible physician is required by law or professional standards to compile and maintain.

(g) "Person" includes any individual, corporation, professional corporation, partnership, unincorporated association, government, government agency, or any other legal or commercial entity.

(h) "Responsible physician" means the physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill, and (2) takes responsibility for providing medical means of suicide to the patient.

(i) "Terminal illness" means a bodily disorder that is likely to cause a patient's death within six months.

SECTION 3. AUTHORIZATION TO PROVIDE ASSISTANCE

(a) It is lawful for a responsible physician who complies in all material respects with Sections 4, 5, and 6 of this Act to provide a patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that

(1) the patient is eighteen years of age or older;

(2) the patient has a terminal illness or an intractable and unbearably illness; and

(3) the patient has made a request of the responsible physician to provide medical means of suicide, which request

(A) is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness;

(B) represents the patient's reasoned choice based on an understanding of the information that the responsible physician has provided to the patient pursuant to Section 4(d) of this Act concerning the patient's medical condition and medical options;

(C) has been made free of undue influence by any person; and

(D) has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

(b) A responsible physician who has provided a patient with medical means of suicide in accordance with the provisions of this Act may, if the patient so requests, be present and assist the patient at the time that the patient makes use of such means, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

SECTION 4. DISCUSSION WITH PATIENT AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness

or alleviating symptoms, including pain and other discomfort;

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services to determine whether services are available to the patient that could improve the patient's circumstances sufficiently to cause the patient to reconsider his or her request for medical means of suicide;

(c) counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest; and

(d) supply to and discuss with the patient all available medical information that is necessary to provide the basis for a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits and burdens, all in accordance with the following procedures:

(1) at least two adult individuals must witness the discussion required by this paragraph (d), at least one of whom (A) is not affiliated with any person that is involved in the care of the patient, and (B) does not stand to benefit personally in any way from the patient's death;

(2) the responsible physician shall inform each witness that he or she may question the responsible physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information discussed pursuant to this paragraph (d); and

(3) the responsible physician shall document the discussion with the patient held pursuant to this paragraph (d), using one of the following methods:

(A) an audio tape or a video tape of the discussion, during which the witnesses acknowledge their presence; or

(B) a written summary of the discussion that the patient reads and signs and that the witnesses attest in writing to be accurate.

The documentation required by this subparagraph (3) must be included and retained with the patient's medical record, and access to and disclosure of such records and copies of them are governed by the provisions of Section 10 of this Act.

SECTION 5. PROFESSIONAL CONSULTATION AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) secure a written opinion from a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness or an intractable and unbearable illness;

(b) secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient and is qualified to make such an assessment that the patient has requested medical means of suicide and that the patient's request meets the criteria set forth in Sections 3(a)(3)(A), 3(a)(3)(B), and 3(a)(3)(C) of this Act to the effect that the request is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, is fully informed, and is free of undue influence by any person; and

(c) place the written opinions described in paragraphs (a) and (b) of this section in the patient's medical record.

SECTION 6. RECORDING AND REPORTING BY THE RESPONSIBLE PHYSICIAN

Promptly after providing medical means of suicide to a patient, the responsible physician shall (a) record the provision of such means in the patient's medical record, (b) submit a report to the Commissioner on such form as the Commissioner may require pursuant to Section 8(a) of this Act, and (c) place a copy of such report in the patient's medical record.

SECTION 7. ACTIONS BY PERSONS (OTHER THAN THE RESPONSIBLE PHYSICIAN

(a) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may, if the patient so requests, be present and assist at the time that the patient makes use of medical means of suicide, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

(b) A licensed pharmacist, acting in accordance with the laws and regulations of this state and the United States that govern the dispensing of prescription drugs and devices and controlled substances, may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means.

(c) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may counsel or assist the responsible physician in providing medical means of suicide to a patient.

SECTION 8. RECORD KEEPING BY THE DEPARTMENT

(a) The Commissioner shall by regulation specify a form of report to be submitted by physicians pursuant to Section 6(h) of this Act in order to provide the Department with such data regarding the provision of medical means of suicide as the Commissioner determines to be necessary or appropriate to enable effective oversight and regulation of the operation

of this Act. Such report shall include, at a minimum, the following information:

- (1) the patient's diagnosis, prognosis, and the alternative medical treatments, consistent with accepted clinical practice, that the responsible physician advised the patient were practicably available;
- (2) the date on which and the name of the health care facility or other place where the responsible physician complied with the patient's request for medical means of suicide, the medical means of suicide that were prescribed or otherwise provided, and the method of recording the discussion required by Section 4(d) of this Act;
- (3) the patient's vital statistics, including county of residence, age, sex, race, and marital status;
- (4) the type of medical insurance and name of insurer of the patient, if any;
- (5) the names of the responsible physician, the medical and mental health consultants who delivered opinions pursuant to Section 5 of this Act, and the witnesses required by Section 4(d) of this Act; and
- (6) the location of the patient's medical record.

(b) The Commissioner shall require that the report described in paragraph (a) of this section not include the name of the patient but shall provide by regulation for an anonymous coding or reference system that enables the Commissioner or the responsible physician to associate such report with the patient's medical record.

SECTION 9. ENFORCEMENT AND REPORTING BY THE DEPARTMENT

(a) The Commissioner shall enforce the provisions of this Act and shall report to the Attorney General and the appro-

pritate board of registration [or similar state agency] any violation of its provisions.

(b) The Commissioner shall promulgate such rules and regulations as the Commissioner determines to be necessary or appropriate to implement and achieve the purposes of this Act and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Board of Registration in Medicine [or similar state agency] for such Board's review and advice.

(c) The Board of Registration in Medicine [or similar state agency] may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the Department promulgated under it and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Commissioner for the Commissioner's review and advice.

(d) The Commissioner shall report to the Legislature annually concerning the operation of this Act and the achievement of its stated purposes. The report of the Commissioner shall be made available to the public upon its submission to the Legislature. In order to facilitate such annual reporting, the Commissioner may collect and review such information as the Commissioner determines to be helpful to the Department, the Board of Registration in Medicine [or similar state agency], or the Legislature and may by regulation require the submission of such information to the Department.

SECTION 10. CONFIDENTIALITY OF RECORDS AND REPORTS

(a) The information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf, except as this Act or any other provision of law may otherwise require.

(b) The report that a responsible physician files with the Department pursuant to Section 6(b) of this Act is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].

SECTION 11. PROVIDER'S FREEDOM OF CONSCIENCE

(a) No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.

(b) A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.

SECTION 12. PATIENT'S FREEDOM FROM DISCRIMINATION

(a) No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan may require any individual to request medical means of suicide as a condition of eligibility for service, benefits, or insurance. No such physician or entity may refuse to provide medical services or medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.

(b) A patient's use of medical means of suicide to end such patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy of insurance on the life of such patient.

SECTION 13. LIABILITY

(a) No person who has acted in compliance with the applicable provisions of this Act in providing medical means of

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suicide to an individual shall be subject to civil or criminal liability therefor.

(b) No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject thereto to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility that complies with Section 11(b) of this Act.

(c) Except as provided in paragraphs (a) and (b) of this section, this Act does not limit the civil, criminal, or disciplinary liability of any person for intentional or negligent misconduct.

SECTION 14. CRIMINAL PENALTIES

In addition to any other civil, criminal, or disciplinary liability that he or she may otherwise incur thereby, an individual who willfully violates Section 3, 4, 5, 6, or 7 of this Act is guilty of a [specify grade of offense].



TO: P.O. CHARLES BARON
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 (617) 552-4376

Message for BARON

from: noel@stanley.newenglandnet.com
 to: Sat, Apr 27, 1996 9:55 AM
 subject: <no subject>
 to: BARON

FROM NOEL EARLY
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Buzz,

I wish I could be with you in Washington on Monday when you talk to those Congressmen. If I were there I would tell them that the terminally ill don't want their protection, they want them off their backs. They need their support. They want to be left free to deal with their own lives, and their own deaths, as they see fit.

I am dying of ALS. My doctors have concluded that I should not expect to live much beyond Christmas of this year. I am likely to begin to experiencing the final (bulbar) stage of the disease in the fall. What I fear is not so much death as what the dying process is sure to become. For people with ALS, this can be really horrific.

Why do other people insist on telling me I must suffer for their sake? I am not a devout Catholic, a Fundamentalist Protestant, or an Orthodox Jew. I would not impose my values on them. Why must they impose their values on me? And what ever happened to the separation of church and state anyway. Why are the religious arguments obfuscating our rational and constitutionally sanctioned rights?

If the Congress of the United States is so concerned with protecting the terminally ill, tell them to pass adequate, comprehensive health care legislation. Tell them to make it financially feasible for patients to get the medicine they need so that they may (in some cases) avoid becoming terminally ill. Tell them to repeal federal drug laws that prevent patients from getting adequate pain medication when they become terminally ill. Tell them that the quality of life is too subjective to legislate.

Are terminally ill patients depressed and thinking in a distorted fashion? Maybe some of us could be made to feel more accepting about life with a terminal illness. But our depression is likely not to be a function of mental illness. It is likely to be a very rational response to an extraordinarily depressing fact -- we are soon to die and, for some of us, no matter what anyone does to comfort us, the dying will be much worse than the death.

When my time comes, I pray that there will be resources to make my passing humane, comfortable, and successful. I do not wish for that panic-filled moment when the taste of a gun barrel precedes the instant of its firing.

With best wishes, and thanks for your sensitive concern,

Mr. CANADY. Thank you, Professor.
Professor Rosenblum.

STATEMENT OF VICTOR G. ROSENBLUM, NATHANIEL L. NATHANSON PROFESSOR OF LAW AND POLITICAL SCIENCE, NORTHWESTERN UNIVERSITY SCHOOL OF LAW, AND VISITING PROFESSOR, ARIZONA STATE UNIVERSITY COLLEGE OF LAW

Mr. ROSENBLUM. Thank you, Mr. Chairman.

I understand that the written testimony that I have submitted will be made part of the record. I also request that three additional documents which are referenced in that written statement be included as appendices in the materials.

Mr. CANADY. Without objection.

Mr. ROSENBLUM. Thank you.

Mr. Mr. , Chairman Hyde, and members of the subcommittee, the views of the ninth circuit in the case of *Compassion in Dying v. Washington*, and of the second circuit in *Quill v. Vacco* should be alarming to all Americans concerned with the fate of our most vulnerable citizens.

In my view, these decisions are marked by four fundamental errors.

First, the opinions distorted our tradition prohibiting assisted suicide.

Second, they misapplied U.S. Supreme Court precedent to fashion an entirely new and insupportable constitutional right.

Third, they improperly held there is no rational basis for maintaining a distinction between the right to refuse life-sustaining medical treatment and physician-assisted killing.

Finally, these two courts dismissed concerns of abuse while fashioning alleged constitutional doctrines that make it inevitable that assisted suicide will expand down that slippery slope of specious reasoning to ever larger classes of persons who will be put to death.

The common law tradition against assisted suicide is not an anachronism, contrary to suggestions by the ninth circuit and Judge Calabresi in the second circuit to substitute some individual judicial policy preferences for established common law legal traditions. These traditions protected vulnerable persons from pressures, overt or subtle, that they end their lives.

In recent decades, since the case of Karen Quinlan, courts and legislatures in virtually every State have struggled with the question, under what conditions life-sustaining medical treatment may be withheld or withdrawn, particularly from incompetent patients.

Although they have recognized a right to refuse treatment, virtually all the decisions have also recognized and affirmed that common law tradition against assisted suicide and euthanasia. Most States have seen no reason to weaken these prohibitions of common law. Indeed, in many cases these prohibitions have been restated or codified in new statutes. The second and ninth circuits somehow misread these developments as undermining the law's traditional prohibition against physician participation in killing.

The circuit courts have attempted to leverage the consensus regarding the right to refuse treatment to bring about support for a judicially created initiative in which there is no legal or medical

consensus. The circuit courts claim to rely on the abortion decisions and on the *Cruzan* case, but there is no support in these precedents for expansion of the privacy or liberty doctrine to protect a right to assisted suicide.

The issue of abortion, as acknowledged in the *Casey* case, is unique. The trimester framework of *Roe v. Wade* has no application to assisted suicide because the lives at issue in assisted suicide are indisputably defined in law as the lives of persons with full protection under the Constitution.

Furthermore, *Casey* is inapplicable to support expansion of a privacy or liberty right because the *Casey* case itself is a decision that restricted and reversed previous decisions of the Supreme Court that expanded the so-called right to abortion.

The *Casey* case cannot be utilized as a roadmap for future expansion of rights not enumerated in the Constitution when the *Casey* court narrowed absolute access to abortion by reversing its previous rulings in the *Akron* and *Thornburgh* cases.

The case's most florid dictum, referring to the right to define one's own concept of existence, was invoked by the court to justify a scaled down abortion right. It cannot, without turning the law on its head, be used to fashion entirely new constitutional rights.

These circuit court decisions also ignore key passages in *Cruzan* in which the Supreme Court explicitly held the State interest in preserving life is unqualified and which also described laws against assisted suicide as part of the legal heritage of all civilized nations.

The circuit courts' decisions hold that the State interest in preserving life is diminished due to a patient's infirmity, a holding that misapplies the State's interest analysis in *Roe v. Wade* while simultaneously ignoring the specific contrary teachings of the *Cruzan* case.

This leads into perhaps the most grievous error in these circuit court decisions: that there is no important State interest or even a rational basis for supporting a continued prohibition against assisted suicide in the case of the terminally ill.

In the *Harris v. McCray* case upholding the Hyde amendment's restrictions on abortion funding, the Supreme Court held that the State's interest in the potential life of the unborn child was a sufficient rational basis for the decision to fund childbirth but not to fund abortion.

Since the Supreme Court has explicitly found that there is a rational basis to favor childbirth over abortion, there is similarly a clear, rational basis to favor the continuity of life and to maintain the distinction between refusing treatment and active killing.

Both the second and ninth circuits refused to acknowledge the salient distinction between killing and allowing a patient to die naturally. The ninth circuit explicitly suggests that it would be rational for the handicapped to seek assisted suicide to end their suffering and further states that terminally ill patients may choose suicide in order to save expense for their families and loved ones.

These two circuit court rulings would transmute the widespread reverence in our Nation for "Fiddler on the Roof's" ode, "To life, to life, l'chayim," into a glorification of pressing fast-forward buttons to premature death.

There is no warrant in the Constitution for overturning the laws of virtually all the States and imposing this policy on the entire Nation without the consent of its elected representatives. I hope and expect that these decisions of the two circuit courts will soon be regarded as the aberrations they are in American constitutional law.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rosenblum follows:]

PREPARED STATEMENT OF VICTOR G. ROSENBLUM, NATHANIEL L. NATHANSON PROFESSOR OF LAW AND POLITICAL SCIENCE, NORTHWESTERN UNIVERSITY SCHOOL OF LAW, AND VISITING PROFESSOR, ARIZONA STATE UNIVERSITY COLLEGE OF LAW

I. INTRODUCTION

Mr. Chairman, members of the committee, I would like to thank you for the opportunity to testify regarding the importance of two recent and disturbing decisions on assisted suicide: *Compassion in Dying v. Washington*,¹ decided March 6 by an en banc panel of the U.S. Court of Appeals for the Ninth Circuit, and *Quill v. Vacco*,² decided April 2 by a three-judge panel of the Court of Appeals for the Second Circuit. The Ninth Circuit decision is particularly regrettable because it vacated a panel decision, written by Judge John T. Noonan, Jr., which eloquently showed why the right to assisted suicide is foreign to our legal traditions and inimical to a genuine understanding of liberty within our constitutional system.

In support of this testimony, I would like to submit three documents for the record: a 1995 Oregon Law Review article by attorneys Edward Grant and Paul Linton,³ the May 1994 Report of the New York State Task Force on Life and the Law,⁴ and the January 1994 Report of the British House of Lords.⁵ Each addresses the legal, ethical, and medical issues connected with the issues of assisted suicide and euthanasia.

My testimony will analyze these decisions in some depth. These are my principal conclusions:

- * First, the Ninth Circuit's holding that there is a constitutional liberty interest in assisted suicide, and the Second Circuit's holding that enforcement of laws against assisted suicide violate principles of equal protection, are contrary to relevant common law and constitutional precedent.
- * Second, both the Ninth and Second Circuit undervalued, and in some case ignored, the compelling interests of the State in preventing physicians from taking actions to directly cause the deaths of their patients.

¹ -- F.3d --, 1996 WL 94848 (9th Cir., 1996), *vacating* 49 F.3d 586 (9th Cir. 1995). Since this decision, the Ninth Circuit has ordered the parties to brief whether the full membership of the Ninth Circuit should rehear the 11-judge en banc decision.

² -- F.3d --, 1996 U.S. App. LEXIS 6215 (2d Cir. 1996), *rev'g* *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994).

³ Edward R. Grant and Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 OREGON L. REV. 449 (1995).

⁴ NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* (1994).

⁵ H.L. REP. OF THE SELECT COMM. ON MED. ETHICS (U.K. 1994)

* Third, the relief fashioned by the Ninth and Second Circuits is inherently elastic. It will expand in future cases to include the direct euthanasia, not only of competent terminally ill patients, but of patients who are incompetent and not terminally ill. These decisions will alter the physician-patient relationship and societal attitudes toward the terminally ill. They introduce a bias in favor of death, and against the more difficult challenge of fully caring for the weak and the vulnerable through the end of their natural lives. Such a bias threatens the inherent dignity of every human person, and will corrupt the delivery of health care to every patient with a life-threatening illness.

II. CONSTITUTIONAL ANALYSIS

First, to briefly summarize the essential holdings of these opinions: The Ninth Circuit broadly held that under the Due Process clause of Fourteenth Amendment, there is a "liberty interest in controlling the time and manner of one's death."⁶ The Court found the Washington statute that prohibits "aid[ing] another person to attempt suicide" is unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians."⁷

In contrast, the Second Circuit expressly denied the existence of any such liberty interest. The court found that two New York statutes prohibiting assisted suicide "do not impinge on any fundamental rights nor can it be said that they involve suspect classifications."⁸ However, because other aspects of New York law permit the withdrawal of life-sustaining treatment, which also may result in death, the court found the assisted suicide prohibition to be a violation of the Equal Protection clause. "[T]o the extent that [these statute] prohibit a physician from prescribing medication to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest."⁹

A. Assisted Suicide in History and Tradition

Our jurisprudence of substantive due process permits the Federal courts to protect rights not specifically enumerated in the Constitution. Lest this power be wielded arbitrarily to frustrate the legitimate enactments of the legislature, the Supreme Court has placed clear strictures on its exercise. First among these is that any "new" rights ought to be protected

⁶ Opinion at 23.

⁷ *Id.* at 39.

⁸ Opinion at 31-32.

⁹ *Id.* at 48.

only if they are "implicit in the concept of ordered liberty"¹⁰ and "deeply rooted in this Nation's history and tradition."¹¹

The Second Circuit correctly found that the asserted right to assisted suicide, even in the very limited cases of competent terminally persons who seek to hasten death, meets neither standard. The court abided by the Supreme Court's admonition that "[t]he Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution."¹²

Stating that analysis of the historical foundations is "useful," but not sufficient for rejecting a claimed liberty interest, the Ninth Circuit presented its own view of the legal history of assisted suicide. The court rejected the conclusions in Judge Noonan's opinion, which were identical to those of the Second Circuit, that a constitutional right to aid in killing oneself was "unknown to the past." The real history, Judge Reinhardt suggests, is far more "checked."¹³

The primary flaw of the Ninth Circuit's historical analysis, however, is that it relegates to secondary consideration the history that is most relevant—the common law and statutes that define the Anglo-American legal tradition regarding suicide and assisted suicide. The court downplays this tradition in favor of "literary" traditions regarding suicide. But evidence of acceptance of suicide among some ancient cultures, the deaths of Jewish resisters at Masada, and the practices of the Sythians or Vikings do not trump evidence of the common law as adopted by the American colonies, or the laws adopted by the States since 1789. The Ninth Circuit's rendition of the history of suicide demonstrates nothing more than what we already knew, and what Judge Noonan clearly knew when he wrote the majority opinion for the original Ninth Circuit panel: that in spite of millennia of philosophical, religious, and legal strictures on the duty to preserve life (including one's own), noteworthy examples of suicide are part of our history, and command study and reflection. They are not to be confused, however, with the Anglo-American legal tradition or American constitutional history.

The second and related flaw is that by focusing almost entirely upon the issue of suicide, the court fails to focus on the specific issue, which is the asserted right to *physician-assisted suicide*. This is a critical distinction. The "literary" suicides invoked by the Ninth Circuit were just that—suicides. They did not involve the assistance of others, in particular,

¹⁰ *Palko v. Connecticut*, 302 U.S. 319, 325 (1937).

¹¹ *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977).

¹² *Id.* at 25, *citing Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

¹³ Opinion at 14.

the assistance of physicians. The Ninth Circuit identifies no tradition of physician involvement in assisting patients to die, other than contemporary reports of physicians who defy the law in this area. The court also ignores a welter of evidence establishing a clear legal consensus against assisted suicide.

As Judge Reinhardt acknowledges, under the English common law, suicide was a crime and subject to varying degrees of punishment from at least the 13th century and into the 19th century. His opinion emphasizes that criminal restrictions against suicide have waned. But he almost completely ignores the most relevant historical fact: that as criminal penalties against suicide were withdrawn in the 19th and 20th centuries, penalties against assisted suicide were codified and strengthened.

For example, Judge Reinhardt claims that at the time of the passage of the Fourteenth Amendment, only 9 States had statutes against assisted suicide. This ignores, first, that at least 12 additional states had adopted the common law of crimes, which treated assisted suicide as a species of homicide, and second, that due to a clear trend of States codifying prohibitions against assisted suicide (including several that have done so in recent years), virtually all States forbid assisted suicide either by express statute (Iowa just became the 34th state to do so), by judicial decision, or by adopting the common law of crimes.¹⁴

Thus, the most relevant aspect of legal history at issue is virtually ignored by the Ninth Circuit. To the extent it is recognized, it is treated as a vestige of the past, not supported in contemporary jurisprudence or statutes. This also is an erroneous characterization. Since 1976, beginning with the case of Karen Quinlan, courts in a number of States have addressed whether there is a constitutional or common law right to refuse life-sustaining medical treatment, and whether such a right may be exercised in the case of an incompetent patient by a surrogate, such as a family member. These have been controversial and difficult decisions, precisely because of concerns that they might involve the medical profession in causing the death of patients. But as the courts pointed out in these cases, the asserted rights to be free of unwanted medical treatment is well-established in the common law, and is not tantamount to a right to suicide or assisted suicide.¹⁵ As stated by the Nevada Supreme Court, "there is a substantial difference between the attitude of a person desiring non-interference with the natural consequences of his or her condition and the individual who desires to terminate his or her life by some deadly means either self-inflicted or through the agency of another."¹⁶ The latter, the courts in all of these cases presumed, remains within the power of the State to prohibit.

¹⁴ Grant and Linton, *supra* note 3, at 483-484.

¹⁵ *Id.* at 462-468.

¹⁶ McKay v. Bergsiedt, 801 P.2d 617, 627 (Nev. 1990).

Recent legislative enactments also confirm this distinction, and the current viability of sanctions against assisted suicide. In addition to the States which have recently codified specific restrictions against assisted suicide, virtually all States have in the past 20 years legislated some form of "advance directive" for health-care decisions at the end of life. Specifically, 45 States and the District of Columbia expressly disapprove of mercy killing, suicide, or assisted suicide in "living will" and durable power of attorney for health care legislation.¹⁷

Based on this evidence, it is clear that a "right" to assisted suicide is foreign both to our legal traditions and our contemporary jurisprudence. Our tradition *has* seen a withering, first of penalties directed against the suicide and his or her heirs, and eventually, of all penalties against acts of attempted suicide. The reasons for this evolution are complex and subject to debate, but we can say with confidence that the reasons did *not* include a belief that suicide is a beneficent or even necessary act in specific cases. If such a belief were the rationale, then we might have expected to see a concomitant lessening of legal strictures against assistance in suicide, on the theory that those for whom suicide would be a "benefit" should have the assistance of others in performing the act.

In fact, precisely the opposite occurred. There has been a steady and unreversed trend toward specific statutory prohibitions against assistance in suicide. Law reformers, such as the drafters of the Model Penal Code, retained such provisions without any exceptions.¹⁸ A single State, Oregon, has enacted legislation to permit assisted suicide in certain cases, but as we have seen, many more States have either rejected such legislation or even strengthened their existing prohibitions.

Against this evidence, the Ninth Circuit posits that current societal attitudes and public opinion support the right of the terminally ill to "die with dignity," that "most Americans simply do not appear to view such acts as constituting suicide," and that "there is much support in reason for that conclusion."¹⁹ To the extent such attitudes are relevant at all—the Supreme Court has never relied upon "contemporary attitudes" to trump a record of consistent legislative action against a particular action for which constitutional protection is asserted—they must be considered in context. First, as previously indicated, the law in this area has been dynamic, not static, during the past generation. Scores of statutes and court opinions have defined rights to refuse life-sustaining medical treatment and the conditions under which the right may be exercised. Second, the refusal of treatment has been distinguished from the practice of assisted suicide. Third, proposals to legalize assisted suicide have consistently failed, save in a single State. (Contrary to Judge Reinhardt's view,

¹⁷ Grant & Linton, *supra* at 462-463.

¹⁸ Grant & Linton, *supra* at 483-484. See also MODEL PENAL CODE § 210.5(2) (Official Draft and Revised Comments 1980).

¹⁹ Opinion at 17-18.

the procedural safeguards in the successful Oregon assisted suicide referendum are no greater than those in the defeated Washington and California referenda on the subject.)

In a representative democracy, these specific legislative enactments and judicial decisions are a far more relevant gauge of societal attitudes than the vagaries of public opinion polls, or anecdotal reports of individuals who choose to violate the law. In particular, the fact that some physicians may now provide assistance in suicide, or even direct mercy-killing, is irrelevant to the constitutional inquiry of whether such laws violate a constitutional liberty interest. "Attitudes" do not define tradition, and the "hidden practices" of a few do not define fundamental rights.

The flaws in the Ninth Circuit's historical analysis are reminiscent of those in the thoroughly repudiated historical excursus of Justice Blackmun in *Roe v. Wade*. The Ninth Circuit, apparently undeterred by the criticism levelled at *Roe*, has opened itself to the same type of attack. Its rendition of history offers no support for the claim that the Due Process clause protects a right to obtain assistance in ending one's life. Such a claim of radical autonomy is foreign to our legal traditions and constitutional history.

B. Assisted Suicide and the Abortion Cases

The court compounds these errors by misconstruing constitutional precedent, in particular, the "privacy" decisions of *Roe v. Wade*²⁰ and *Planned Parenthood v. Casey*²¹, to support the proposition that the Due Process clause grants broad protection to all decisions relating to "personal dignity and autonomy." The Supreme Court has never enunciated such a broad standard. Indeed, the Court has rejected such claims on several occasions, including in *Roe v. Wade* itself.

The abortion cases, *Roe* and *Casey*, are among the most misunderstood decisions in American constitutional law. I understand that this point was explained thoroughly by Professors Mary Ann Glendon and Douglas Kmiec at a hearing before this Subcommittee just last week.²² I will defer to their analysis, and mention only one key point that I believe flows from their testimony: The problems spawned by *Roe* and *Casey* should, if anything, make the Federal courts more hesitant to carve out new constitutional rights that will result in the destruction of human life.

²⁰ 410 U.S. 113 (1973).

²¹ 505 U.S. 833 (1992).

²² *The Origins of Roe v. Wade: Hearings before the Subcommittee on the Constitution of the Committee on the Judiciary, U.S. House of Representatives*, April 22, 1996 (Statements of Mary Ann Glendon and Douglas Kmiec).

The Ninth Circuit did not heed this lesson and instead, engaged in a facile analysis that reads into *Roe* and *Casey* principles that are not present in those decisions, and ignores the important doctrinal constraints that are present.

For example, the court declares that the decision to end one's life in order to avoid suffering "is highly personal and intimate," and thus subject to the same protection provided in *Roe* to a woman's decision to end a pregnancy. While plausible on its face, this equation overlooks several points. First, *Roe* and the cases on which it relied were concerned with procreation and childbearing, matters that are traditionally the province of the family. Suicide has no connection with this tradition of privacy in matters related to the family, and neither *Roe* nor any of the cases on which it relies suggests otherwise. Second, *Roe* specifically rejected the notion that one has an absolute right to do with one's body as one pleases, and thus rejected radical autonomy as a foundation for rights under the Due Process clause.

Third, on the critical question of the value of life, *Roe* recognized that if the unborn child were regarded as a constitutional person, there could be no right to abortion because the State would have a compelling interest in protecting the life of the child. Although *Roe* declined to so treat the unborn child, it is crystal clear that persons who would be subject to assisted suicide are constitutional persons, and thus merit the protection of the State until their natural death. The entire *Roe* framework of trimesters and evolving rights and interests is entirely irrelevant to the case of assisted suicide. The unique status of *Roe* is illustrated by the court's decision, in the same Term that *Roe* was decided, in *Paris Adult Theatre I v. Slaton*.²³ There, the Court referred with approval to then-unchallenged laws banning [assisted] suicide.

The Ninth Circuit also relied on a selective reading of *dicta* in *Planned Parenthood v. Casey* to support its broad notions of autonomy. Admittedly, the language in *Casey* stating that "the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life"²⁴ is capable of broad application. But this *dicta* should not be confused with constitutional doctrine, and should not be reflexively applied to matters outside the scope of the narrow issue before the Court in *Casey*.

That issue was whether the Court should overturn its earlier, controversial ruling in *Roe*—not whether a new right should be created. By the narrowest of majorities, the Court declined to do so. The Court's meditations on the extent of liberty was a defense of its prior decision, not an invitation to the declaration of other novel constitutional rights. And the specific language in question is preceded by a discussion of the constitutional protection

²³ 413 U.S. 49 (1973).

²⁴ 505 U.S. at 851.

given to marriage, procreation, contraception, and the rearing and education of children, thus closely tying the Court's more florid language directly to established precedent.

Precedent, in the end, was what *Casey* was about. The Court repeatedly drew the distinction between the decision to overturn existing precedent and to fashion new precedent. This was seen most clearly in the Court's admonition that, even if *Roe* had been decided in error, principles of institutional integrity and the public's reliance on established doctrine militated against an abrupt reversal of the decision. These factors are clearly not present in the case of assisted suicide, where existing precedents clearly oppose the claimed "liberty interest."

In addition, the Court in *Casey* emphasized the singular position of its abortion decisions on the spectrum of constitutional law: referring to *Roe* as a "sui generis" extension of prior decisions on the family and procreation; characterizing abortion as a "unique act;" and describing the liberty interests of the pregnant woman "as unique to the human condition and so unique to the law."²⁵ These statements, ignored by the Ninth Circuit, are dispositive on the question of whether *Casey* mandates recognition of an asserted constitutional right to assisted suicide. Far from being "prescriptive" on the question, as the Ninth Circuit states, *Casey* is really of very limited precedential value.

Finally, the claimed right to assisted suicide illustrates the danger in literal application of the *Casey* dicta on the "meaning of life" to novel claims of constitutional right. In the panel decision for the Ninth Circuit, Judge Noonan demonstrated that if applied outside the abortion context, this language would be illimitable. Criteria such as "suffering" are inherently subjective and clearly are not limited to the terminally ill. The romantically-disillusioned twenty-year old and the depressed forty-year old may find life just as burdensome as a terminally ill person in his sixties or seventies. If a right to assisted suicide is predicated on an individual's unrestricted right "to define one's own concept of existence . . . and of the mystery of human life," there is no principled basis on which exercise of the right could then be restricted to those who are terminally ill.

C. Assisted Suicide and the Right to Refuse Medical Treatment

1. The Impact of *Cruzan*

The Ninth Circuit, and the Second Circuit in *Quill v. Vacco*, equated the right to assisted suicide with the evolving right to refuse life-sustaining medical treatment. In doing so, they ignored the legislative enactments of virtually every State, and the unanimous judgment of the State courts that have ruled on this issue, that exercise of the common-law right to refuse even life-sustaining medical treatment is not tantamount to suicide. This disregard of precedent is all the more remarkable due to the vast professional literature and

²⁵ 505 U.S. at 852.

widespread public discussion of these issues since the decision of the New Jersey Supreme Court regarding Karen Quinlan, exactly 20 years ago.

Both courts also misread *Cruzan v. Director, Missouri Dept. of Public Health*,²⁶ in which the Supreme Court presumed, but did not decide, that a competent patient has the right to refuse unwanted medical treatment, and may refuse assistance in feeding, even if this will result in death. The Ninth Circuit held that in so ruling, the Supreme Court "necessarily recognizes a liberty interest in hastening one's own death."²⁷ The Second Circuit, relying in part on Justice Scalia's concurring opinion, declared that there can be no logical distinction between causing one's death by the refusal of treatment and causing one's death by more direct means.²⁸ The Second Circuit glossed over the fact: (1) that Justice Scalia would permit the State far greater latitude in prohibiting decisions to withdraw certain forms of life-sustaining medical treatment, (2) that he would clearly uphold State decisions to prohibit active assistance in suicide, and (3) as a fundamental matter, that he would reserve all such questions to the people and their elected representatives—the entire point of his *Cruzan* concurrence:

[T]he point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate" are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory It is quite impossible . . . that they will decide upon a line less reasonable.²⁹

Admittedly, there are certain circumstances in which decisions to withdraw medical treatment or to stop feeding a patient come close to assisted suicide or even euthanasia. These cases are particularly troubling when they involve severely disabled individuals who have played no part in the decision to withdraw treatment. They are far less troubling, for example, when a terminally ill patient decides to forego care that will be futile in preserving life, and chooses to die at home or under hospice care.

However, even in the more difficult cases, there is a critical distinction: Death, if it does result, occurs because of an underlying pathology, and not as the result of a lethal agent prescribed or administered by a physician. Moreover, from a jurisprudential point of view, the decision to decline treatment or to reject assistance in feeding is based on principles of informed consent and battery that are of long-standing in the common law. Thus, the right

²⁶ 497 U.S. 261 (1990).

²⁷ Opinion at 21.

²⁸ Opinion at 41.

²⁹ 497 U.S. at 296.

to refuse medical treatment finds substantial support in our history and tradition, and thus, holds a credible claim to recognition as a liberty interest protected by the Fourteenth Amendment. The right to assisted suicide has no such pedigree. Indeed, as illustrated above, the refinement of the right to refuse in recent decades was accompanied by an affirmation of the need for continued restrictions on assisted suicide. Thus, the claim presented in *Cruzan* was supported by the very form of tradition and history that is completely lacking in the case of assisted suicide. The Ninth Circuit and the Second Circuit attempt to leverage this traditional foundation for the right to refuse treatment into support for the right to assisted suicide. This is a fundamental error of these decisions.

Moreover, these decisions give insufficient weight to the tensions between the claimed liberty interests and the competing State interests, as they are discussed in *Cruzan*. The premise that patients have the right to consent to or to refuse medical treatment reached judicial and legislative attention when medical science expanded its ability to sustain life through "artificial" means. As *Cruzan* recognized, these developments brought two legal traditions into potential conflict: the right to consent or not to consent to treatment, and the interest of State in preventing homicide, including assisted suicide. On this latter point, the Court's endorsement of State interest was unequivocal: "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide."³⁰ The Court noted that the Constitution "protects an interest in life as well as an interest in refusing life-sustaining medical treatment."³¹

Thus, *Cruzan* concerned itself with a very narrow issue: whether Missouri's requirement of clear and convincing evidence of a patient's intent to refuse treatment violates constitutional rights. The Court held in the negative, but in so doing, placed no outer limits on the State's ability to assert its interest in sustaining life. In other words, the Court in no way suggested that a ban on active assistance in suicide would be constitutionally impermissible. To the contrary, the previous citations from *Cruzan*, particularly its invocation of State laws against assisted suicide, suggest that such laws would not be invalidated. In addition, the Court repeatedly stressed that where death is a potential consequence of an action, the recognition of a "liberty interest" in that action does not end the constitutional inquiry. Instead, the Court stated that "the dramatic consequences [death] involved in the refusal of such treatment would inform the inquiry as to *whether the deprivation of that interest is constitutionally permissible*."³² Thus, the Court left open the possibility that even if assisted suicide were recognized as a species of "liberty," countervailing State interests could support a prohibition of the practice.

³⁰ 497 U.S. at 280.

³¹ 497 U.S. at 281.

³² 497 U.S. at 279.

Finally, *Cruzan* also specifically denied that the State must tailor its interests in light of the diminished life expectancy of an individual, a central theme of the Second and Ninth Circuit opinions. The Court affirmed that the State may assert an "unqualified" interest in the patient's life,³³ and require *heightened* procedures precisely due to the vulnerability of the patient's condition. One must bypass this aspect of *Cruzan* almost completely, as did the majority in both *Quill* and *Compassion in Dying*,³⁴ to find that the State has no legitimate interest in protecting the lives of terminally ill patients from the practice of assisted suicide.

2. The Distinction Between Withdrawing Treatment and Suicide

As mentioned, both the Second and Ninth Circuits attempt to leverage the consensus supporting the right to refuse medical treatment into a broader "right to die" that now encompasses assisted suicide, and in the future, will likely include active euthanasia. The Ninth Circuit, in fact, explicitly holds that the right to assisted suicide may be exercised by a "duly-appointed surrogate"—thus meaning that the right is *not* limited to competent patients.

This tactic, to blur the distinction between withdrawing treatment and direct assistance in killing, is favored by pro-euthanasia advocates for obvious reasons. By placing these very different practices under the all-encompassing rubric of a "right to die," they avoid having to make the case for dismantling centuries of legal precedent opposing assisted suicide, as well as millennia of ethical teaching that forbids physician participation in causing the deaths of their patients. In fact, these advocates often eschew the terms "assisted suicide" and "euthanasia" in favor of more palatable terms, such as "physician aid-in-dying."

It is one thing for social advocates to engage in such linguistic sleight-of-hand. It is quite another for our Federal courts to adopt the practice, as has occurred in both opinions here.

Both courts gloss over the fundamental distinction between omission and commission, between allowing a patient to die and killing the patient. The Second Circuit used this equivocation to create an Equal Protection Clause claim; the Ninth Circuit used it to create a Due Process Clause claim: since there is a right to refuse unwanted life-sustaining medical treatment, the court reasoned, there must be a corollary right to enlist the assistance of a physician in directly causing one's death. The Ninth Circuit in particular attempts to make the case that the prescription of lethal medication to a terminally ill patient should not even be considered assistance in suicide, but merely as an effort to ensure that the patient's inevitable death will be humane and dignified.

³³ 497 U.S. at 279-282.

³⁴ The Ninth Circuit dismissed this aspect of *Cruzan* on the species rationale that if the State's "unqualified" interest is not always controlling because if it were, "the draft, as well as the defense budget, would be unconstitutional." Opinion at 22, and note 72.

As previously discussed, other legal authorities dismiss this point of view. "Virtually without exception, the judicial decisions and statutes in this area have recognized the distinction between directly causing death by an affirmative act ending life and allowing death to occur by withholding or withdrawing life-sustaining medical treatment."³⁵ The vast body of legal and medical literature supporting this distinction makes the following points:

First, there is an ethical distinction between act and omission. Though the Ninth Circuit views this as a distinction without a difference, there is a clear analytical difference between actively causing one's death by introduction of an artificial agent and passively allowing death to occur from natural causes by refusing instrumentalities to prolong life. If this were not the case, no omission of a potentially life-sustaining treatment would be ethical, and physicians and patients would be obliged to use all possible means to sustain life in all cases.

Second, the right to refuse life-sustaining medical treatment articulated during the past two decades evolved out of the common law of battery and informed consent, and is properly classified as a negative right: the right *not* to be subjected to treatment, particularly treatment that is burdensome and carries an uncertain hope of benefit to the patient. The Ninth Circuit concludes that the rationale for permitting the withholding treatment is to allow patients to hasten their deaths; however, it is clear from the dozens of judicial decisions on this subject that they are predicated on refusing burdensome medical treatment and not on a general right to hasten death.

Third, as drilled into first-year students of criminal law, criminal culpability often hinges on the concept of intent. If the rationale of the Ninth Circuit were taken to its logical conclusion, every decision by a physician not to employ a life-sustaining medical treatment, or to withdraw such a treatment with the consent of the patient or family members, could constitute a form of homicide, a deliberate hastening of death. As the courts recognized in *Quinlan* and subsequent cases, this has never been the law, and if it were, would hopelessly confuse the application of the criminal law in such matters.

The intent involved in foregoing life-sustaining treatment is different from the intent involved in actively killing a patient or providing the means for a patient to commit suicide. In the former case, the direct intent is to forego treatment, to omit an action that is not obligatory under the law. While one may know or expect that death will ensue, that knowledge or assumption does not rise to the level of criminal intent. Indeed, the assumption may prove incorrect. Consider the case of Karen Quinlan: the parents were granted a right to refuse the use of the respirator, but they declined to withdraw her nourishment. The medical prognosis that she would die without the respirator proved false and she continued to live for several years. In the latter case, such as prescribing lethal doses of medication, only one intent may be inferred—the intent to cause death. (The issue

³⁵ Grant and Linton, 74 OREGON L. REV. at 461-462.

is these cases is not the right to prescribe pain medication that may have the secondary effect of causing death, but the right to prescribe medications whose sole purpose is to cause death.) The claim presented in these cases, therefore, is to establish constitutional protection for actions that have heretofore been prohibited because they exhibit a homicidal intent.

Finally, these distinctions apply even in cases where the withdrawal of treatment—i.e., the cessation of feeding—will most certainly result in death. The distinctions between omission and act, and between intending to refuse unwanted treatment and intending to directly cause death still apply to these cases. The withdrawal or withholding of medically-assisted feedings constitutes the refusal of a treatment that may sustain life but, especially for those in the last phases of a terminal illness, may appear unduly burdensome and hence, non-obligatory.

Admittedly, such cases appear *close* to the actual causation of death, particularly if the patient's death is not imminent. This being the case, special concerns and safeguards often accompany such decisions, and the Supreme Court in *Cruzan* endorsed State efforts to attach the highest burden of proof to such cases where they involve incompetent patients. But as the courts also have ruled, assisted feeding remains a medical treatment, and thus remains within the ambit of the common-law right of competent patient to consent to or to refuse. Such rulings should be seen as the factual endpoint of the jurisprudence commencing in *Quintan*, and not a departure point for creating a new right to assisted suicide and euthanasia. Clearly, it is constitutionally permissible for the States to draw a clear line between omissions and acts, even if some of the permitted omissions will have the same result as all of the forbidden acts.

D. Equal Protection and the Rational Basis for State Prohibition of Assisted Suicide

The Second Circuit held that because there is no rational basis for distinguishing between a death resulting from the omission of unwanted medical treatment, and a death resulting from suicide. I find the court's conclusion on these points incomprehensible and without any foundation in Supreme Court precedent.

First, as the Second Circuit acknowledged, terminally ill patients who are not dependent upon life support do not constitute a "suspect class" within the meaning of the Fourteenth Amendment. Thus, even if such patients were being treated differently from patients who are dependent upon life support, the state would merely have to show a rational basis for the distinction.

One need look no further than the decisions of the Supreme Court in *Harris v. McRae*³⁶ and *Williams v. Zbaraz*³⁷ to find a rational basis to support the distinction

³⁶ 448 U.S. 297 (1980).

preserved not only by New York, but as discussed previously, by virtually every State in the Union. In *Harris* and *Williams* the rational basis was clear: Congress, through the Hyde Amendment, and the States through their own statutes, could choose to fund the expenses of childbirth, but not of abortion, in order to express "the legitimate [governmental] interest in protecting potential life."³⁸ The Court acknowledged that "[a]bortion is inherently different from other medical procedures because no other procedure involves the purposeful termination of human life."³⁹ Similarly, assisted suicide is inherently different from any other aspect of medical care, including decisions to forego unwanted treatment. Only assisted suicide (and its logical consequence, active euthanasia) involve the deliberate and intentional taking of human life.

Second, assisted suicide prohibitions are laws of general application. Thus, there is no disparate treatment at all. The patients at issue enjoy the same right to refuse unwanted medical treatment as all other patients. Conversely, the prohibition against active assistance in suicide applies equally to those dependent on life support and those not dependent on life support. What the plaintiffs in these cases are claiming, and what the Second Circuit has unfortunately endorsed, is an *unequal* application of the laws against assisted suicide. Under the court's ruling, these laws will apply to some persons, and not others. The only "equality" that is achieved by this decision is an equality of *results*: the sought-after result being death. Nothing in the Constitution requires a State to fashion its laws to achieve such a strained equality, particularly when it places at risk fundamental competing State interests.

Third, as discussed previously, there are numerous rational grounds for distinguishing between the withdrawal of medical treatment, or even the cessation of feeding, and active assistance in death. To summarize, a State is free to give expansive protection to the common-law right to refuse medical treatment, a right that finds substantial support in our legal history and traditions, while at the same time prohibiting active assistance in death, a practice that finds no support in that history or tradition.

Fourth, a State may rationally conclude that maintaining prohibitions against assisted suicide is an essential part of the jurisprudence fashioned since *Quinlan* on the right to refuse life-sustaining treatment. A clear understanding that the law would not allow doctors to actively kill their patients made it possible to debate under what circumstances physicians could allow their patients to die without the use of invasive medical technology. Introducing the concept of physician-assisted killing would upset the entire set of assumptions upon which the rules for allowing withdrawal of treatment are based—which is evidence by the consistent declarations in recent statutes and judicial opinions that allowing a patient to die does not constitute suicide or homicide. Maintaining this distinction is thus an integral part of this

³⁷ 448 U.S. 340 (1980).

³⁸ *Harris*, 448 U.S. at 325.

³⁹ *Id.*

complex body of jurisprudence fashioned by our States in the past two decades. The Second Circuit's attempt to erase this distinction is not only a direct assault on the fundamental interest of the State in preserving life, but threatens the entire body of jurisprudence supporting the right to refuse treatment.

Finally, there are numerous specific grounds derived from the general interest in preserving life that justify a state's decision to draw the line between omission and act, and hold fast to the distinction set forth in the law of New York. Many of these grounds are discussed in the Report of the New York State Task Force. The Task Force was "particularly struck by the degree to which requests for suicide assistance by terminally ill patients are correlated with clinical depression or *unmanaged* [not unmanageable] pain, both of which can ordinarily be treated effectively with current medical techniques."⁴⁰ It noted studies which demonstrate that suicidal ideation is rare among terminally ill patients, unless those patients are also suffering from depression.⁴¹ It also observed that the elderly and terminally ill are less likely to receive appropriate diagnosis and treatment for depression. The Task Force stated that, "[a]s a society, we can do far more to benefit these patients by improving pain relief and palliative care than by changing the law to make it easier to commit suicide or to obtain a lethal injection."⁴²

The Task Force also addressed the dangers of implementing a policy of assisted suicide for vulnerable patients whose access to medical care and other needed services is already tenuous.

Assisted suicide and euthanasia would carry us into new terrain—American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnosis and treat depression in many cases. The risks would extent to all individuals who are ill. They would be most severe for those who autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.⁴³

⁴⁰ WHEN DEATH IS SOUGHT. *supra* note 4 at ix.

⁴¹ *Id.* at 12-17, 127.

⁴² *Id.* at 9.

⁴³ *Id.* at vii-viii.

States are clearly free to enact statutes against such dangers, and there is an equally clear rational basis to do so.

Before concluding this discussion of the Second Circuit decision, I would like to touch upon the provocative concurring opinion of Judge Calabresi. His opinion is premised on the judgment that New York's prohibition against assisted suicide is archaic because it was enacted in the 19th century and thus reflects neither the advances in medical science since that time, nor the developing jurisprudence on the right to refuse life-sustaining medical treatment. He would require the New York legislature to go back to the drawing board and re-articulate its grounds for maintaining such a prohibition and, he broadly hints, to provide certain exceptions to the prohibition.

While provocative in typical Calabresian fashion, this approach is not likely to emerge, as one New York *Times* commentary suggested, as a viable alternative to the path followed by the Ninth Circuit. Indeed, it is vulnerable to criticism as an even more radical extension of judicial authority. Judge Calabresi proposes to require that a state take a "second look" at older statutes that are not clearly unconstitutional, but which are "constitutionally suspect"—on the ground that the state must articulate a specific and contemporary rationale for upholding the provision.⁴⁴ This, of course, is the ordinary task of the Attorney General and other officers whose duty it is to defend legislative enactments, a task which was ably performed in this case by two Attorneys General of the State of New York. Judge Calabresi's approach moves the courts away from deciding specific cases and controversies, and toward the role of advisory overseers of constitutional doctrine. This undermines the principles of justiciability embodied in the "cases and controversies" language in section 2 of Article III of the Constitution, and erodes predictability in constitutional decision-making.

Finally, Judge Calabresi's assumption that laws against assisted suicide are an anachronism misapprehends the facts. New York and other states have considered these issues intently during the past two decades, and uniformly reached the same result: that laws against assisted suicide are still important and necessary, and should be retained despite (and perhaps because of) developments in the law regarding the withdrawal of treatment. If any further evidence of this were required, it is found in the Report of the New York State Task Force. His argument that laws against assisted suicide have ceased to be constitutional because of changes in society and medical practice is curious, and well-refuted.

E. Contradictions Between the Second and Ninth Circuit Opinions

As we consider the potential long-term impact of these decisions, it is noteworthy to point out the contradictions in the analysis employed by the Ninth and Second Circuits. Although the result of each was to invalidate the respective state prohibitions on assisted

⁴⁴ Opinion at 84-85.

suicide, the contradictions in their analysis are telling and illuminate why there is no constitutional basis for their respective holdings.

The Ninth Circuit concluded that assisted suicide is a species of "liberty" under the Due Process clause of the Fourteenth Amendment. The Second Circuit dismissed a similar claim, finding that such a right as has no basis in our legal history and traditions.

The Ninth Circuit concluded that the due process right extended to competent patients who are "terminally ill," and could be exercised on behalf of incompetent patients through a surrogate. The Second Circuit limited the prescription of lethal drugs to patients in "the final stages of a terminal illness," and made no mention of extending the right to incompetent patients.

The Ninth Circuit found a right to physician-assisted suicide; the Second Circuit held that a doctor could only prescribe drugs for a patient to "self-administer."

Reconciling these decisions would in all likelihood result in movement closer to the position of the Ninth Circuit: a broadly-defined "right to die" that can be exercised by all terminally ill patients, and on behalf of those terminally ill patients who cannot act for themselves. Once the principle of physician participation in directly causing the death of patients is accepted, the practice will likely extend to a broader class of patients seeking this avenue of "relief."

III. THE ELASTICITY OF THE RIGHT TO ASSISTED SUICIDE

The Ninth and Second Circuits attempted to head off such arguments by emphasizing that the right to assistance in suicide is limited to certain classes of persons, and can be subject to State regulations and even prohibitions. However, the doctrinal holdings of the decisions are likely to erode such regulations as "undue burdens" upon the rights these cases have established.⁴⁵

First, the right to assisted suicide recognized in these decisions is in principle illimitable. It cannot be restricted to the mentally competent terminally ill, or more specifically, to those whose deaths are imminent. The Ninth Circuit stated that there is a "liberty interest in determining the time and manner of one's death." If this is true, could this liberty be denied to a patient upon initial diagnosis of an inevitably fatal disease, or of a degenerative condition such as Alzheimer's? Such patients could claim an interest in preventing the slow process of disease and suffering. Their families and caregivers could thus be relieved of the burdens of care that often attend such conditions. The Ninth Circuit endorses such thinking: "Faced with the prospect of astronomical medical bills, terminally

⁴⁵ This point is eloquently discussed by Professor Kamisar in the appendix to his testimony.

ill patients might decide it is better for them to die before their health care expenses consume the life savings they planned to leave for their families, or, worse yet, burden their families with debts they may never be able to satisfy . . . [W]e are reluctant to say that . . . it is improper for competent, terminally ill adults to take the economic welfare of their families into consideration."⁴⁶

Second, terminal illness is itself an arbitrary boundary. Ironically, patients who are chronically ill but not terminally ill, and suffering from their illness, might well claim a denial of the equal protection of the laws if a state legalized assisted suicide only for the "benefit" of the terminally ill. If the right were extended in this fashion, it would be a small step to acceptance of assisted suicide for the handicapped, particularly those who are perceived to have a low "quality of life." The Ninth Circuit treats this concern with two responses: First, it asserted that the handicapped and disabled "are sufficiently active politically and sufficiently vigilant" to prevent actions which would pressure them into taking their own lives. Second, it suggested that "seriously impaired" individuals will be the *beneficiary* of the right to assisted suicide, because otherwise, they will be compelled to "ensure unusual and protracted suffering."⁴⁷

This effective endorsement of assisted suicide for the severely handicapped demonstrates that the "boundaries" established by the Ninth Circuit are inherently subjective—the "terminal illness" criterion carries an implicit judgment that some lives are not worth living and hence, that it is reasonable that such lives be ended. For example, the Ninth Circuit concedes that the state *does* have an interest in preventing suicides by teens and young adults and "in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, *which can be significantly ameliorated*."⁴⁸ Thus, the court concluded, suicide is senseless for some; for others it is not. The distinction lies in the dangerous notion of "quality of life." The Second Circuit echoed this line of reasoning, referring to the "greatly reduced interest of the state in preserving life" in the case of a terminally ill patient. However, there is no issue in these cases of the State requiring additional means to sustain life; the State's only claim in that the lives of the terminally ill, like those of all other citizens, be protected under generally-applicable laws against assisted suicide.

Third, the criterion of "suffering," often used to defend the right to assistance in death for the terminally ill, is similarly subjective. The New York State Task Force discussed this problem:

⁴⁶ Opinion at 29.

⁴⁷ *Id.* at 28.

⁴⁸ *Id.* at 24 (emphasis supplied).

[A]s long as the policies hinge on notions of pain or suffering they are uncontainable; neither pain nor suffering can be gauged objectively or subjected to the kind of judgments needed to fashion coherent public policy. Moreover, even if the more narrow category of terminal illness is chosen at the outset, the line is unlikely to hold for the very reason that it has not been selected by advocates of assisted suicide—the logic of suicide as a compassionate choice for patients who are in pain or suffering suggests no such limit.⁴⁹

Both the Second and Ninth Circuit explicitly cite suffering as grounds for diminishing the State interest in the lives of terminally ill patients. Neither adequately considers that the option of aggressive pain management, and not hastening death, is the reasonable response to such circumstances—or that the imperus to treat pain and suffering will diminish if the option of hastened death can be presented to the patient.

Fourth, the criteria of competency and "self-deliverance" of the means of death are not genuine limits. As mentioned, the Ninth Circuit specifically endorsed the practice of assisted suicide, with the consent of a duly-appointed surrogate, in the case of an incompetent patient. The court left unanswered the question of how an incompetent patient can commit suicide. Clearly, such cases would require the direct killing of the patient by the physician. The court takes no position on this issue, but clearly indicates that the liberty interest "in controlling the manner of one's own death" would be broad enough to encompass such practices.

These points illustrate that, in the words of the British House of Lords Report, that assisted suicide is not "a discrete step which need have no other consequences." The House of Lords Committee Report emphasizes that "individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions." The Committee concluded:

[I]ssues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such

⁴⁹ WHEN DEATH IS SOUGHT, *supra* note 4, at 15.

that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address.⁵⁰

The seeds of such expansion are well-planted in the opinions of the Second and Ninth Circuits.

IV. ASSISTED SUICIDE AND HUMAN DIGNITY

These opinions further suggest that assisted suicide is necessary so that terminally ill patients can end their lives in a dignified and humane fashion. The Second Circuit asks: "What business is it of the state to require the continuation of agony when the result is imminent and inevitable?"⁵¹ Aside from noting that the state does not require the prolongation of life in such circumstances, this admittedly is a difficult question to answer. But so is the following question: "What business does the state have in deciding that some lives are less worthy of the law's protection than others, and suggesting through legalization of assisted suicide that this is a 'rational' way for people to end their lives?" This question, as noted by the earlier panel decision of the Ninth Circuit, is of greater relevance. The license for assisted suicide will inevitably affect society at large, not merely a handful of exceptional cases.

There is perhaps a universal temptation to surrender to the stress and tension of a chronic, longterm illness, and to despair of any relief, to give up hope of recovery, to abandon the family member in need, and inevitably, to hasten the death of the chronically ill patient. Technology has not alleviated these concerns, but neither should technology be viewed as the sole source for aggravating them. It is because of human nature itself that there is an enduring need for the protection embodied in the common law, and now codified in the law of most States.

Overturning this tradition on the basis of an unenumerated constitutional "liberty interest," or obliterating the historical distinction between act and omission, threatens the values that the law has long sought to protect. The House of Lords Committee spoke to the importance of laws prohibiting assisted suicide and euthanasia in protecting the dignity of the person:

The right to refuse medical treatment is far removed from the right to request assistance in dying. We spent a long time considering the very strongly held and sincerely expressed views of those witnesses who advocated voluntary euthanasia Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing.

⁵⁰ H.L. REP., *supra* note 5 at 49.

⁵¹ Opinion at 43.

That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.⁵²

Against such a background, there are fundamental problems with the decisions of the Second and Ninth Circuits. As a legal matter, the decisions ignore an unimpeachable legal tradition of protecting the most vulnerable among us. This tradition grows out of the common law and continues through the legal and medical reforms of the past 20 years. As a factual matter, these decisions assume that the State and medical practitioners can effectively limit the practice of physician-assisted death only to those who are truly terminally ill, truly competent, and truly free of depression, duress, or other undue influences upon their decision. As an constitutional matter, the decisions presume that courts are the appropriate institutions to assess the wisdom of public policies on these questions, and that their judgments should trump those of the elected branches of government. The Ninth and Second Circuit decisions are profoundly wrong on all three counts.

V. CONCLUSION

The implications of legalizing assisted suicide are not speculative. They have been thoroughly explored and documented, an endeavor furthered by the record created at this hearing. Even if some States might unwisely experiment with legalizing assisted suicide, there is no constitutional warrant for overturning the laws of virtually all the states and imposing this policy on the entire nation without the consent of its elected representatives.

I hope and expect that these decisions will one day be regarded as aberrations in American constitutional law. I would be pleased to answer any further questions you may have. Thank you for the opportunity to testify at this important hearing.

⁵² *Id.* at 48.

Mr. CANADY. Thank you, Professor.

On our last panel, Dr. Quill said that physicians should be prohibited from introducing the option of assisted suicide to the patient. Let me ask Ms. Lee and Professor Baron, in the case of the two—in the case of the initiative you supported, Ms. Lee, and the case of the model statute that you have helped formulate, Professor Baron, would the physician be prohibited from introducing assisted suicide as an option to the patient?

Ms. LEE. Mr. Chairman, the Oregon Death with Dignity Act was structured in such a way that the request must originate with the individual. Once that request has originated from the individual, then certain duties arise for the physician to notify about alternatives, to counsel regarding comfort care, palliative care, pain relief, all those sorts of things. But the triggering event that calls all of those duties up is a request from the patient.

Mr. CANADY. But is there anything that would prohibit the physician from encouraging the patient to make such a request?

Ms. LEE. As I said, the act is structured as a safe harbor. It grants immunities for physicians who abide by its provisions. It authorizes responding to a request but does not authorize a physician to raise the option.

Mr. CANADY. But it doesn't prohibit it either.

Ms. LEE. It would not award the immunities to a physician who began the conversation.

Mr. CANADY. Even if the request subsequently came from the patient.

Ms. LEE. Well, it is just not structured that way. It is structured in such a way that the triggering event, as I said, arises from the patient.

Mr. CANADY. Professor Baron.

Mr. BARON. I agree that I would not—excuse me. Again, I forgot the microphone.

Yes, I agree. I would not want physicians initiating the idea or putting it into the patient's head, and also our act would not extend immunity from prosecution to any physician who did so. There are all sorts of procedural requirements with respect to making sure that this is a voluntary request.

So we have introduced in the statute, first of all, consultation with a psychiatrist. It is required that a psychiatrist or some psychologist—

Mr. CANADY. But the underlying question I have asked: Where is it exactly in your model statute that the physician is prohibited from raising the issue?

Mr. BARON. Specifically, there is no provision except for all the procedural safeguards with respect to making sure that it is voluntary. The fact that—

Mr. CANADY. I understand that, but the physician could bring it up as long as the other procedures were followed subsequently?

Mr. BARON. I suppose as long as someone afterward were convinced that despite the fact in the first instance it was mentioned by a physician that this was still voluntary, then that would be possible. But I take it you are suggesting that you would prohibit that because you think it would make it involuntary. Isn't that why you raised the question?

Mr. CANADY. I am just trying to get a good handle on how this works. I have a little bit of a problem saying this is a fundamental right. And you aren't going to be able to tell people this is their fundamental right. I think there is a little bit of an inconsistency.

Mr. BARON. I never said, however, that it was their fundamental right.

Mr. CANADY. I think some people who were advocating this do believe——

Mr. BARON. No. In the article we suggest——

Mr. CANADY. I don't mean——

Mr. BARON. This is something which probably should not be constitutionalized in the first instance.

Mr. CANADY. I don't attribute that characterization to you, but that is a characterization that certainly could be attributed to the ninth circuit, and in the context we are dealing that has to be considered.

Professor Kamisar.

Mr. KAMISAR. First of all, a number of Dutch doctors have written that they do bring up the subject, so we know that at least it does go on there.

Second of all, whether it is a fundamental right or not, if it is legal, if it is a reasonable alternative, it is a medical procedure. I have a hard time calling it a medical procedure, but that is what it would be.

It seems to me the doctor ought to tell his patient, or her patient, what option she has, what medical procedure she has available. There is a recent article by Dr. Daniel Callahan and Margo White in which they say just that.

Finally, I don't know how you could prevent it. Obviously, the spouse is likely to bring it up. A spouse or other relative is likely to say to the patient: "What about this option? You ought to ask your doctor. I understand that they are doing this nowadays, and you ought to find out more about the procedures for assisted suicide." There is nothing to prevent a member of the family or a close friend from suggesting the patient ask the doctor.

I don't know how you could enforce a prohibition against the physician raising the topic, what with the doctor-patient privilege, the confidentiality of records and so forth. It is not that it would be involuntary, if a doctor brings it up, you wonder, maybe I ought to think about that. Obviously the doctor thinks I might be a candidate. I don't know if it would be involuntary, but it would still be unpleasant.

Mr. CANADY. Let me ask this: This brings up a question of medical ethics. If it is available, is it unethical for the physician to fail to make the patient aware? Would that be a breach of the physician's duty? What do you think about that? I know you are not a physician, Professor Baron, but——

Mr. BARON. No. I think of course physicians have to be concerned—all of us are concerned with the voluntary nature of this request, and if we weren't concerned about corrupting its voluntariness——

Mr. CANADY. Back on the question I asked——

Mr. BARON. Right. What I am suggesting is, if the physician worries that by his suggesting it, it will be his decision and not the

patient's decision, it seems to me that medical ethics dictates he not raise it. And I think that Yale Kamisar, with his usual insight, has suggested that it would normally be unnecessary because the patient will have some idea. The patient is going to ask, if the patient is desperate enough, "Isn't there something you can do?"

In a way, I think it is a false question, but I am concerned, as you are, that this be a voluntary request.

Dr. KRAUTHAMMER. Mr. Chairman, if I may.

Mr. CANADY. Yes, Dr. Krauthammer.

Dr. KRAUTHAMMER. I think this distinction that Professor Baron is drawing between voluntary and involuntary is rather spurious. It is as if it either is or it isn't; there is no in between.

What we are talking about here are the inevitable pressures that will occur on people in this kind of vulnerable position in which they will be driven to accepting, by their own signature of course, as happens in Holland, their own death in circumstances in which they might not otherwise have.

If people around you are dying in great numbers, as happens in Holland, people in your circumstances, and you know it is occurring, of course you may end up deciding, yes, I will do it, and under the kind of legalistic interpretation of Professor Baron, that would be voluntary.

But I think the public policy issue here is, do we want to construct a system under which thousands of people will be initiating their own death in circumstances in which they are doing so because of the pressures that have been created around them, including the pressures from the family and from the physician?

Mr. CANADY. Ms. Lee, do you wish to comment on that?

Ms. LEE. I thought I might speak to the question of physician ethics. I think you referenced the physician's duty to inform individuals when they are considering a procedure of the alternatives and the risks? In other words, obtaining an informed consent from a patient before instituting some sort of procedure. And you are right, that does have firm grounding in professional ethics, and it also has codification in most States.

In Oregon it is codified in a statute that requires that physicians inform individuals that there are alternatives to the procedure that they are suggesting. So if a physician suggests some palliative care procedure Oregon law would require that they tell the patient that there are alternatives. And then if the patient said, "What are the alternatives?" the physician has the duty to tell the patient the alternatives they consider reasonable.

That has never been interpreted to mean that the physician must exhaustively go through every conceivable alternative—for instance, acupuncture, homeopathy, and chiropractic and all sorts of things that physicians don't do in their practices that others might consider an alternative.

In Oregon we were careful to maintain a strict adherence to the right of providers to not provide the service if they chose not to, and that includes not bringing it up and not including it in their alternatives.

Mr. CANADY. If, pursuant to that provision of Oregon law, they brought up the availability of assisted suicide, based on your earlier comment, would the physician who brought it up because he

felt constrained to do so not be given the advantage of safe harbor under the Death with Dignity Act?

Ms. LEE. If the physician brings it up, he or she would not attain the immunities under the Death with Dignity Act.

Mr. CANADY. Mr. Frank.

Mr. FRANK. Thank you.

Let me ask Dr. Krauthammer: You said you thought the court—as I said, I don't know if the Oregon decision came up when I was there. Would you be in favor of overturning that district court decision in Oregon and living—

Dr. KRAUTHAMMER. If you heard my testimony, you would have heard me say, even though I disagree with Oregon and even though I believe in the long run, I suspect there will be a lot of pressure in the legislatures and in referendum—

Mr. FRANK. You would be for overturning the decision?

Dr. KRAUTHAMMER. It is decided by a democratic—

Mr. FRANK. You misheard my question. I said, would you be for overturning the district court decision? The district court threw out the law, as I understand it, in Oregon. You would be for overturning the district court decision?

Dr. KRAUTHAMMER. Threw out which law, Mr. Frank?

Mr. FRANK. The Oregon law.

Dr. KRAUTHAMMER. The referendum, you mean?

Mr. FRANK. Yes. As I understand it, and maybe I got the facts wrong, but the Federal district court in Oregon suspended a State-authorized—I assume you would—

Dr. KRAUTHAMMER. I personally would not approve of that, of overturning it.

Mr. FRANK. You think the district court decision should be overturned?

Dr. KRAUTHAMMER. My position is consistent.

Mr. FRANK. I am glad your position is consistent, but forgive me for not—I am just trying to ask you a specific question. I am glad your position is consistent. That is not my major focus right now. I want to make sure we understand it. We have had a misunderstanding of terms. You would be for overturning that district court decision in Oregon?

Mr. KRAUTHAMMER. For the decision which overturned the referendum? Yes.

Mr. FRANK. As I read your testimony, I didn't see any reference in the Oregon law.

Mr. KAMISAR. The Oregon district court decision has been overturned by the ninth circuit.

Mr. FRANK. I understand that, but the ninth circuit is not before me now, but the witnesses are, and I would like to ask them. The reason I say that, in part, was, I do think that consistency is important, let me say.

I didn't remember quite as much outcry about judicial interference when the district court suspended the Oregon law in which two circuits suspended the Washington and New York laws. I think there may be consistency when people are asked, but I think intellectual consistency, consistency of indignation—

Dr. KRAUTHAMMER. Don't you think the circuit decision has a little more impact than a district court decision?

Mr. FRANK. I know that it does, but when the district court decision came first, and I didn't hear that outcry, I am a little—excuse me. The fact is—you have been testifying. I do want to make my point. When the district court decision came out before the circuit court decisions, I didn't hear anything.

Now it is true, once the circuit court decisions were made, they had more significance. But I will also insist that a district court decision that has been made has more significance than circuit court decisions that have not been made. I did not hear any great outcry about the district court decisions. And I do want to say now it is kind of hard for people to segment that. But I would have been more reassured about the consistency of the commitment to principle if I heard those—maybe people have them. If someone would send them to me, I would be glad to receive them.

I don't remember the same kind of criticism of judicial interference when a Federal district court knocked out the Oregon law.

Mr. KAMISAR. Last September at a conference held in Washington, I did—even though I am opposed to assisted suicide, I did criticize—and it is written up in an issue of U.S. Law Week—I did criticize the Oregon district court—

Mr. FRANK. You would say this is a matter that should not be constitutionalized one way or the other? It should be up to the legislatures?

Mr. KAMISAR. That is right.

Mr. FRANK. Are there restrictions on what the legislature can do? Because one of the questions Ms. Coleman asked—and I thought it was a challenging question on behalf of the people who are disabled—is it inherently discriminatory to limit this right to people who are perceived to be terribly disabled? If there was a right of assisted suicide, are we logically compelled? If a legislature did it, would there be an equal protection argument against it unless they did it for everybody?

Ms. Coleman's arguments seem to be, if you in fact allowed it only for people who were physically disabled or severely physically disabled, that you—and not others—that you might have an equal protection problem. That hadn't occurred to me before.

I am just wondering, Professor, if that would be a problem.

Mr. KAMISAR. That was the theory of the district court in Oregon, that it only singled out terminally ill people and therefore it put this—it didn't provide them the same protection against coercion to elect assisted suicide that other people had, and of course the ninth circuit said it is a benefit, not a burden.

Mr. CANADY. The gentleman will have 3 additional minutes.

Mr. KAMISAR. I think her main point is this: That by saying—

Mr. FRANK. I understand her main point. Let me say, Professor, she was quite explicit and clear.

Mr. KAMISAR. You are asking a good question. There has been almost no thinking about the limits on legislation of the other way.

Mr. FRANK. Suppose the legislature did say, if you want to commit suicide, that is your business, and in fact if you believe in the principle that anyone had a right to commit suicide and ask for the assistance of another, someone who was not ill, someone who was not under any disability, it would presumably be easier to meet the coercion argument.

What about if a statute were to be passed that said anybody who wants to can commit suicide and may, if clearly established, ask another for permission, should the court strike that down?

Let me ask each of the witnesses. Nothing is pending before us. We have the luxury of being somewhat expansive in looking at the implications about it.

If you haven't thought about it—

Ms. LEE. I haven't thought about it.

Mr. KAMISAR. I think it would be an unfortunate statute. I would fight against it. If there were a bill that said mentally competent people who persist in wanting assisted suicide for whatever reason they think is a good reason, I would oppose it. But it seems that would be the logical followup, the ultimate conclusion where the ninth and second circuits have put us now.

Mr. CANADY. You wouldn't support a court striking that down?

Mr. KAMISAR. No, I wouldn't.

Mr. KRAUTHAMMER. It is the logic of any law that permits assisted suicide to permit it to any rational person who demands it. Why it should be restricted to the terminally ill seems to me to be sort of incomprehensible to me. If it is based on a notion of autonomy, why do the terminally ill have autonomy and not the bereaved?

Mr. KAMISAR. It is limited to the terminally ill because assisted suicide for the terminally ill has the most support, and once you establish it for the terminally ill, then you can take the next step.

Mr. FRANK. Professor Baron.

Mr. BARON. Thank you.

Well, there is already precedent for this. Indeed, initially the right to refuse treatment was, by most statutes, restricted to the terminally ill. The same with many of the first decisions. But it seems to me it makes a tremendous amount of sense to start on that basis.

I am as worried as everyone else about discrimination here, but the fact is that one person's slippery slope is another person's common law development. The law has always seen a tremendous amount of wisdom, whether it is developing law through the courts or through the legislatures, with taking one step at a time.

The thing I think is most ridiculous about Judge Hogan's opinion in *Lee v. Oregon*, which is the court opinion you have been talking about, is that it is the terminally ill who are asking for this legislation. It is those of us who are worried about what is going to happen to us when we are terminally ill who are asking for this legislation. It is not the rest of us who are trying to take advantage of the terminally ill, it is the terminally ill who are asking for the right to make their own decision. When other people ask for that same right, we can respond to it then.

Mr. CANADY. The gentleman's time has expired. The gentleman has 1 additional minute.

Mr. ROSENBLUM. I find the entire presupposition here of voluntary behavior on the part of the terminally ill a very difficult and inappropriate supposition to make.

The common law has traditionally recognized that actions which are taken under duress are not voluntary actions, and in most of the cases that we are dealing with in cases where people who are

terminally ill, we are dealing with people who are responding to duress. They are not engaged in the normal activities of lifetime which we could label as voluntary.

May I just respond very quickly?

I think it makes sense from a policy perspective and also an equal protection argument. The State's interest in preserving life is a strong one, and I don't bicker with that at all. However, the State's interest in preserving life diminishes with the terminally ill.

Mr. FRANK. Would you therefore rule that across the board with regard to people who are terminally ill? Should we then assume they have no autonomy in any decision they make?

Mr. ROSENBLUM. I may be one who respects autonomy but certainly not in regard to taking life.

Mr. FRANK. You already said that. I am talking about—that is not what you said. You said they are under duress and therefore they have no autonomy. It seems your argument goes too far and deprives them of any autonomy. They then become—you make them nonpersons.

Mr. ROSENBLUM. I would differ with you.

Mr. CANADY. The gentleman's time has expired.

Professor, I will yield to you if you wish to follow up on that.

Mr. ROSENBLUM. With all respect, Congressman, I think there is a vast difference between a decision to take one's life and the ordinary decision with regard to, say, paying a bill or not paying a bill.

Mr. FRANK. There is a difference as to whether or not you have autonomy, though. If you are dying, you might decide you have less need to pay the bill.

Mr. CANADY. I am going to recognize Mr. Hyde.

Mr. HYDE. Thank you very much, Mr. Chairman.

Professor Baron, you read a letter that you received from somebody. It was a fascinating letter. It was kind of hard-hitting and made some strong points.

I have a letter, now that we are into reading letters, I would like to read to you. It is far from a hard-hitting letter; it is kind of soft. It is dated October 30, 1995, and it was addressed to our chairman, Charles Canady, and it is from Oak Park, IL, an area I used to represent. They reapportioned me out of there, but it is a great section of the Chicago area, and it says:

Dear Congressman Canady: Opponents of H.R. 1833, the Partial Birth Abortion Ban Act, claim that partial birth abortion is justifiable when performed on babies with disabilities. Please consider the personal experience of our family as you debate H.R. 1333 on the floor of the House. In June 1993 I was 5 months along, carrying twins. My husband and I were notified that one of the twins, our daughter Mary, suffered from a severe neural tube defect, that Mary's prognosis for life was slim and her chance at normal development nonexistent. Her severe abnormality complicated the twin pregnancy, and specialists encouraged amniocentesis in Mary's abortion, though entitled to live out her allotted time without being assaulted by instruments or chemicals. When it became clear that Mary, whose brain had developed outside of her skull, an ancipitalencephalocele, would not survive normal labor, we opted for a Cesarean delivery.

Born December 13, 1993, a minute after her healthy big brother, Will, Mary lived 6 hours cradled peacefully in her father's arms. She was with us long enough to greet her grandparents and our close friends. She also gave a special gift to other children, the gift of life. On the day of her funeral, we received a letter from the Regional Organ Bank of Illinois. Our daughter's heart valves were a match for two Chicago infants critically ill at the time of Mary's death. We have learned that even an encephalic baby can give life or sight or strength to others. The death of a child is the most tragic experience many of us will ever face. As parents, we can do only

what we can—ensure that our children do not suffer. As we now know, when their natural time comes, it can be comfortable that their short life has become a gift to others. Our daughter, living less than a day, saved the lives of two other children. Which of us, even after decades of living, can make the same claim?

For the apropos perhaps of what we are talking about but on the value of life and good coming out of great tragedy, I think it is worth noting. And so I have one question for Ms. Lee.

Cost is a huge concern, as we know, in medicine, and many people fear that suicide is going to become a cheap alternative for continued treatment for the terminally ill.

Now you were a driving force to make Oregon the first State to ration health care on the basis of cost-effectiveness. You are also the vice president of a successful HMO.

On December 6, 1994, in an article in the Statesman Journal, you reported that State funding of assisted suicide, quote, “would meet a need without further burdening the medical system that already labored under huge costs,” closed quote. You said, “it’s not as though this is a big ticket item. The writing of a prescription is not expensive.”

From the perspective of cost management then, would you say assisted suicide is an inexpensive substitute for skilled pain management and costly extended care?

Ms. LEE. Mr. Hyde, I think that the audience will miss the thrust of the article from those quotations that were in error and taken out of context.

The thrust of the article is that I do have grave concerns about cost cutting in managed care organizations, HMO’s and others. I have the most grave concerns when it comes to procedures that are potentially curative and are at great cost to the organization. So for instance, early—

Mr. CANADY. The gentleman will have 3 additional minutes.

Ms. LEE. Early in the treatment of potentially fatal disease, I feel that a managed care organization may deter or have subtle incentives not to choose very expensive procedures such as bone marrow transplants or bioengineered drugs in favor of less aggressive and more conservative therapies that may not have the same opportunities for cure.

Those are big tickets items. That is what I meant by that. Those are big ticket items that physicians might actually notice in their withholdings and bonuses when it came Christmastime.

However, the patients that we are talking about are people who have already exhausted all of their potentially curative therapies. The vast expense of their disease treatment is already over. They are at the point of being in hospice and other palliative care modalities that are very, very cost-effective. They are not expensive.

The choice between assisted dying and another week of hospice is not something that the physician is going to notice in the withhold and in the amount of incentive that he or she receives. Therefore, I have a lot less concern about how the incentives fall out there than how they do earlier in the treatment.

Mr. HYDE. Well, I have to leave, and I will come back, Mr. Chairman. I have to speak with some people downstairs.

I visit a nursing home every week, and it is like a dash of cold water in my face. I see these people, who are two points or two

steps from being vegetative, lining up for their meal. That is all they have to look forward to in life, and I have never—I never become callous to it.

I can see if this becomes a way of life, the pressures to get rid of those people that will make—frankly, make Hitler look like a piker. That is my personal feeling.

I think the cost element—we Republicans are viewed as number crunchers lacking vision and compassion. I see the argument, and it is not a crazy argument, that cost is a factor, and it is. Microsurgery of a cerebral aneurysm is very costly, cheaper to let the person die. But, boy, that moves us toward a culture of death. That moves us toward an acceptance of an option that I hate to see us move towards, and that is just my own feeling.

Professor Kamisar.

Mr. KAMISAR. Yes, I think there is one comment that Mr. Early made that everybody in this panel would agree with—repeal Federal drug laws that prevent patients from getting adequate pain medications when they become terminally ill.

Those of us who are opposed to assisted suicide have to do more than just oppose it, and it seems to me that one of the big reasons that people want that option is, they feel they are suffering too much, and so forth.

About the letter generally, it is a very powerful letter, and I don't want to seem insensitive. All I can say is, we can all tell stories. Herbert Hendin can tell stories the other way; I can tell stories the other way. We are not going to decide—we shouldn't decide public policy by anecdotes. We shouldn't decide public policy by very compelling, exceptional cases.

Mr. HYDE. What we learn about the value of life and those of us old-fashioned enough to still use the phrase "sanctity of life" sometimes from these anecdotes.

I agree with you, policy should not be anecdotal. I agree with you completely.

Mr. KAMISAR. I think more powerful than any one letter is the finding that 90 percent of people who commit suicide do so while they have a diagnosable psychiatric illness, and that is equally true in the suicides among the elderly.

The suicidologists—the people who study why people commit suicide, people like Herbert Hendin—most of them are against legalizing assisted suicide. They are not religious, they are not "in the Pope's pocket," they are doing it for nonreligious reasons. It seems to me that is a very serious factor to take into account. They know more about this subject than anybody else.

Mr. HYDE. My time is up. I have lots of questions about surrogates, about what happens to the autonomy of the patient who can't express his or her views because they have been unconscious, and a surrogate deciding a patient should die, for whatever reasons.

I think this is a whole field we could spend a day on, Mr. Chairman, but my time is up, and before I leave, I just want to say it has been—this is a great panel. It has been a great subject, and we could do a lot more of these.

Thank you.

Mr. CANADY. Thank you.

I do wish we had time for a second round of questions for this panel. Your testimony has been very helpful, and there are questions I would like to explore further. Unfortunately, time does not permit. We have to move on to the third panel.

I want to thank each of you for your very valuable testimony, and I would like to ask the members of the third panel to come forward and take your seats.

Mr. CANADY. I will proceed with the introductions of the witnesses on our final panel today. The first witness on the final panel this afternoon is Dr. Lonnie Bristow. Dr. Bristow practices internal medicine in San Pablo, CA. He currently serves as the president of the American Medical Association. He will be presenting the AMA's position on physician-assisted suicide.

Following Dr. Bristow will be Bishop John Shelby Spong. Bishop Spong was ordained into the Episcopal Church in 1976 and since served in several parishes.

Following Bishop Spong, we will hear from Dr. Leon Kass. Dr. Kass is the Addie Clark Harding Professor in the College and the Committee on Social Thought at the University of Chicago. He has written extensively on biomedical ethics and the ethics of everyday life, with special attention to issues surrounding the beginning and end of life as well as the ethical character of the medical profession.

Next to testify will be Roy Torscano. Mr. Torscano will show a videotape of Dr. Albert Rosen. Dr. Rosen is suffering from terminal cancer and believes he has only a few months to live.

Our final witness today is Dr. Carlos Gomez. Dr. Gomez is currently an assistant professor of medicine at the University of Virginia School of Medicine and has written a book entitled, "Regulating Death: Euthanasia and the Case of the Netherlands and Protocols for the Use of Life-Sustaining Treatments."

I want to thank each of you for being with us here this afternoon. Without objection, your complete statements will be made a part of the record. I would ask that you summarize your testimony in 5 minutes. We have not honored the 5-minute rule earlier today. I would encourage each of you to try to stay as close as possible. Some of the witnesses may have other engagements shortly.

Again, thank you for being with us.

Dr. Bristow, please commence.

STATEMENT OF LONNIE L. BRISTOW, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION

Dr. BRISTOW. My name is Lonnie Bristow, M.D. I practice internal medicine in San Pablo, CA, and I also serve as president of the American Medical Association.

Mr. Chairman and members of the committee, for nearly 25 centuries physicians have vowed to give no deadly drug if asked for it nor make a suggestion to this effect. What has changed then that there should be this attempt to make assisted suicide an accepted practice of medicine?

Physical pain hasn't really changed over time, but our perception and needs at the end of life have changed. Advances in medicine and technology allow us to intervene positively in the dying process as we never have before. In this high-tech environment, we have

to find ways to give care that is both compassionate and meets the individual needs of the patient. Calls for legalization of physician-assisted suicide point to a public perception that these needs are not being met by the current health care system and society in general.

It is this issue, how to provide quality care at the end of life, which the AMA believes should be our legitimate focus. Let me be clear in this. The AMA believes that physician-assisted suicide is unethical and fundamentally inconsistent with the pledge physicians make to devote themselves to healing and to life.

Physicians also have an ethical responsibility to relieve pain and respect their patient's wishes regarding care. It is when these duties converge at the bedside of a seriously or terminally ill patient that physicians are torn.

The AMA believes that these ethical duties require physicians to respond aggressively to the needs of patients at the end of life with adequate pain control, emotional support, comfort care, respect for patient autonomy, and good communications.

Efforts are necessary to better educate physicians in the areas of pain management and effective end-of-life care. Patient education is the other essential component of effective outreach.

Our goal is to minimize the circumstances which might lead a patient to request physician-assisted suicide, such as inadequate social support, the perceived burden to family and friends, clinical depression, loss of self-esteem, and the fear of living with chronic unrelieved pain.

AMA takes seriously its role as a leader in issues of medical and professional ethics. The AMA's "code of ethics" serves as the profession's defining document as to what is right versus what is wrong in medical practice, and such issues are critical to our professionalism and our role as healers. My primary obligation as a physician is to first be an advocate for my patient. If my patient is understandably apprehensive or afraid of his or her own mortality, I need to provide information, support and comfort, not help them avoid the issues of death.

Proponents of assisted suicide cite a fear of prolonged suffering and unmanageable pain to support their position. However, recent studies indicate that patients who request physician-assisted suicide are rarely suffering intractable pain. In patients for whom intractable pain is the issue, a physician may too often be reluctant to prescribe adequate pain medication partially out of fear of unjustified criminal prosecution. In some instances administration of adequate pain medication will have the secondary effect of suppressing respiration, thereby hastening death, and that is referred to as the "double effect."

The distinction between this action and assisted suicide is crucial. If there are no alternatives but to increase the risk of death in order to provide comfort, the physician ethically may and should exercise that option. In this circumstance, the physician's clinical decision is guided by the intent to provide pain relief rather than an intent to cause death.

The distinction between withholding or withdrawing treatment and providing assistance in suicide is critical. One allows death to proceed naturally, with the underlying disease being the cause of

death. The other requires action to cause death, independent from the disease process.

The AMA is uniquely capable of educating physicians and the public as to end-of-life care issues. We are currently designing a comprehensive physician education outreach to instruct physicians both in conducting advanced care planning and managing palliative care with their patients. We are particularly concerned with enabling physicians to support patient autonomy, providing patients with sufficient facts to make informed decisions regarding their end-of-life treatment.

Last October, the AMA jointly published a booklet with the American Bar Association and the AARP entitled, "Shaping Your Health Care Future." This gives information about advanced care planning and also a portable model advanced directive for physicians and patients.

In conclusion, Mr. Chairman, the movement to legalize physician-assisted suicide is not a victory for personal rights. It is really a sign of society's failure to address the complex issues raised at the end of life for patients in need. We have the tools to effectively manage end-of-life pain, and to offer terminally ill patients dignity, and to add value to their remaining time. Our response should be a better informed medical profession and public working together to preserve fundamental human values at end of life.

Thank you, Mr. Chairman.

Mr. CANADY. Thank you Dr. Bristow.

[The prepared statement of Dr. Bristow follows:]

PREPARED STATEMENT OF LONNIE R. BRISTOW, M.D., PRESIDENT, AMERICAN
MEDICAL ASSOCIATION

My name is Lonnie R. Bristow, MD. I practice internal medicine in San Pablo, California, and I also serve as President of the American Medical Association (AMA). On behalf of the AMA, I appreciate the opportunity to present our views on physician-assisted suicide to this Subcommittee.

For nearly 2,500 years, physicians have vowed to "give no deadly drug if asked for it, [nor] make a suggestion to this effect." What has changed, that there should be this attempt to make "assisted suicide" an accepted practice of medicine? Certainly the experience of physical pain has not changed over time. Yet the blessings of medical research and technology present their own new challenges, as our ability to delay or draw out the dying process alters our perceptions and needs.

Our efforts in this new paradigm must recognize the importance of care that relieves pain, supports family and relationships, enhances functioning, and respects spiritual needs. Calls for legalization of physician-assisted suicide point to a public perception that these needs are not being met by the current health care system. In addition, society has not met its responsibility to plan adequately for end-of-life care. It is this issue -- how to provide quality care at the end of life -- which the AMA believes should be our legitimate focus.

The AMA believes that physician-assisted suicide is unethical and fundamentally inconsistent with the pledge physicians make to devote themselves to healing and to life. Laws that sanction physician-assisted suicide undermine the foundation of the patient-physician relationship that is grounded in the patient's trust that the physician is working wholeheartedly for the patient's health and welfare. The multidisciplinary members of the New York State Task Force on Life and the Law concur in this belief, writing that "physician-assisted suicide and euthanasia violate values that are fundamental to the practice of medicine and the patient-physician relationship."

Yet physicians also have an ethical responsibility to relieve pain and to respect their patient's wishes regarding care, and it is when these duties converge at the bedside of a seriously or terminally ill patient that physicians are torn.

The AMA believes that these additional ethical duties require physicians to respond aggressively to the needs of the patients at the end of life with adequate pain control, emotional support, comfort care, respect for patient autonomy and good communications.

Further efforts are necessary to better educate physicians in the areas of pain management and effective end-of-life care. Patient education is the other essential component of an effective outreach to minimize the circumstances which might lead to a patient's request for physician-assisted suicide: inadequate social support; the perceived burden to family and friends; clinical depression; hopelessness; loss of self-esteem; and the fear of living with chronic, unrelieved pain.

ETHICAL CONSIDERATIONS

Physicians' Fundamental Obligation: The physician's primary obligation is to advocate for the individual patient. At the end of life, this means the physician must strive to understand the various existential, psychological, and physiological factors that play out over the course of terminal illness and must help the patient cope with each of them. Patients who are understandably apprehensive or afraid of their own mortality need support and comforting, not a prescription to help them avoid the issues of death. Patients who believe sudden and "controlled" death would protect them from the perceived indignities of prolonged deterioration and terminal illness must receive social support as well as the support of the profession to work through these issues. Providing assisted suicide would breach the ethical means of medicine to safeguard patients' dignity and independence.

Pain Management and the Doctrine of Double Effect: Many proponents of assisted suicide cite a fear of prolonged suffering and unmanageable pain as support for their position. For most patients, advancements in palliative care can adequately control pain through oral medications,

nerve blocks or radiotherapy. We all recognize, however, that there are patients whose intractable pain cannot be relieved by treating the area, organ or system perceived as the source of the pain. For patients for whom pain cannot be controlled by other means, it is ethically permissible for physicians to administer sufficient levels of controlled substances to ease pain, even if the patient's risk of addiction or death is increased.

The failure of most states to expressly permit this practice has generated reluctance among physicians to prescribe adequate pain medication. Additional uncertainty is produced by the potential for legal action against the physician when controlled substances are prescribed in large amounts to treat patients with intractable pain. This uncertainty chills physicians' ability to effectively control their terminally ill patients' pain and suffering through the appropriate prescription and administration of opiates and other controlled substances. In this area, states such as California and Texas have developed clear legislative guidance that resolves these concerns for most physicians. The AMA is developing similarly structured model legislation for state medical societies to pursue with their state legislatures and medical licensing boards.

In some instances, administration of adequate pain medication will have the secondary effect of suppressing the respiration of the patient, thereby hastening death. This is commonly referred to as the "double effect." The distinction between this action and assisted suicide is crucial. The physician has an obligation to provide for the comfort of the patient. If there are no alternatives but to increase the risk of death in order to provide that comfort, the physician is ethically permitted to exercise that option. In this circumstance, the physician's clinical decision is guided

by the intent to provide pain relief, rather than an intent to cause death. This distinguishes the ethical use of palliative care medications from the unethical application of medical skills to cause death.

Distinction Between Withholding or Withdrawing Treatment and Assisted Suicide: Some participants in the debate about assisted suicide see no meaningful distinction between withholding or withdrawing treatment and providing assistance in suicide. They argue that the results of each action are the same and therefore the acts themselves carry equal moral status. This argument largely ignores the distinction between act and omission in the circumstances of terminal care and does not address many of the principles that underlie the right of patients to refuse the continuation of medical care and the duty of physicians to exercise their best clinical judgment.

Specifically, proponents who voice this line of reasoning fail to recognize the crucial difference between a patient's right to refuse unwanted medical treatment and any proposed right to receive medical intervention which would cause death. Withholding or withdrawing treatment allows death to proceed naturally, with the underlying disease being the cause of death. Assisted suicide, on the other hand, requires action to cause death, independent from the disease process.

The "Slippery Slope": Physician-assisted suicide raises troubling and insurmountable "slippery slope" problems. Despite attempts by some, it is difficult to imagine adequate safeguards which could effectively guarantee that patients' decisions to request assisted suicide were unambivalent,

informed and free of coercion.

A policy allowing assisted suicide could also result in the victimization of poor and disenfranchised populations who may have greater financial burdens and social burdens which could be "relieved" by hastening death. As reported two years ago by the New York State Task Force on Life and the Law (composed of bioethicists, lawyers, clergy and state health officials), "[a]ssisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care."

Recent studies documenting reasons for patient requests for physician-assisted suicide speak to our "slippery slope" concerns. Patients were rarely suffering intractable pain. Rather, they cited fears of losing control, being a burden, being dependent on others for personal care and loss of dignity often associated with end-stage disease.

The Case of the Netherlands: While euthanasia and assisted suicide are not legal in the Netherlands, comprehensive guidelines have been established which allow physicians to avoid prosecution for the practice. Despite this environment, Dutch physicians have become uneasy about their active role in euthanasia, prompting the Royal Dutch Medical Association to revise its recommendations on the practice.

Findings of more than 1,000 cases of involuntary euthanasia in the Netherlands should raise hackles in the United States, particularly given the stark societal differences between the two countries. Health coverage is universal in the Netherlands, the prevalence of long-term patient-physician relationships is greater and social supports are more comprehensive. The inequities in the American healthcare system, where the majority of patients who request physician-assisted suicide cite financial burden as a motive, make the practice of physician-assisted suicide all the more unjustifiable. No other country in the world, including the Netherlands, has legalized assisted suicide or euthanasia. This is one movement in which the United States should not be a "leader."

EDUCATING PHYSICIANS AND PATIENTS

At its last meeting in December of 1995, the AMA House of Delegates adopted recommendations from a report issued by its Task Force on Quality Care at the End of Life (see appendix). The report identified issues involved with care of the dying, including the need to develop a definition of "futility," provision of optimal palliative care, legislation ensuring access to hospice benefits, and the importance of advance care planning as a part of standard medical care. Based on the report's recommendations, the AMA is coordinating its current efforts and developing a comprehensive physician and patient education outreach campaign regarding quality of care at the end of life.

The AMA is uniquely capable of educating physicians and other caregivers, legislators, jurists, and the general public as to end of life care issues. Recognizing the profession's desire to structure discussions of end-of-life care and maintain an active and improved role in the care of dying patients, the AMA is currently designing a comprehensive physician education outreach to instruct physicians in conducting advance care planning and managing palliative care with their patients. In fostering such communication, the AMA is particularly concerned with enabling physicians to support patient autonomy, providing patients with sufficient background and support to make informed decisions regarding their end-of-life treatment.

In October of 1995, the AMA, with the American Bar Association (ABA) and the American Association of Retired Persons (AARP), jointly published the booklet "Shaping Your Health Care Future," which offers information about advance care planning and a portable model advance directive for physicians and their patients. The guide also provides explicit instructions for including expressed wishes in the patient's record to ensure that they will be honored. A copy accompanies this testimony. The AMA is working with HCFA to facilitate distribution of this valuable resource to Medicare enrollees. We are also in discussion with the U.S. Consumer Information Center to promote broader public distribution of the booklet.

In supporting professional education, the AMA's continuing medical education division, in cooperation with the United States Air Force Reserve, produced a four-part video series, "The Ethical Question: Decisions Near the End of Life." The videos include discussions of patient autonomy, awareness of legal requirements, allocation of scarce resources and emphasis on

compassionate care. Such videos are valuable educational tools, stimulating thoughtful discussion physician to patient or with groups of either patients or physicians. The AMA was also actively involved in the development of the Education Development Corporation workshop, "Decisions Near the End of Life," an institution-based program to train caregivers facing ethical decisions regarding dying patients.

Through continued educational efforts, physicians are committed to demonstrating their enduring commitment to providing the best patient care during every stage of life. Furthermore, provided the tools to facilitate improved terminal care, physicians can readily answer many of the arguments of assisted suicide's proponents.

MEDICARE AND MEDICAID COVERAGE

A significant portion of end-of-life care is provided under Medicare and Medicaid, with estimates showing that Medicare and Medicaid beneficiaries account for 65% of all deaths that occur each year in the United States. Based on the patient populations served by these two programs -- the elderly, the disabled, the poor, and the bulk of the nation's nursing home patients -- this is not surprising. While these programs have supported the establishment and expansion of the hospice benefit, end-of-life care for most Medicare and Medicaid patients is provided in hospitals. Under Medicare, hospital coverage is provided through the prospective pricing system based on the appropriate Diagnosis Related Group (DRG) payment amount. HCFA has announced that it is

working with the Milbank Memorial Fund to explore the possibility of establishing a DRG for hospital inpatient care services related to palliative care for "final" illnesses. Consistent with this direction, AMA is asking the Current Procedural Terminology (CPT) Editorial Panel to consider the potential for development of CPT codes to identify physician services for palliative care.

SIGNIFICANT JUDICIAL DECISIONS

Troubling decisions in the Ninth and Second Circuits have held that state laws in Washington and New York prohibiting physician-assisted suicide could not be upheld. Notably, while both decisions were based on constitutional arguments, the constitutional bases cited were different in each case.

In the Ninth Circuit Court of Appeals in California, the panel overruled an earlier finding in the case *Compassion in Dying v. Washington*, finding a constitutional right to physician assisted suicide for terminally ill, competent adults who wish to hasten their death. The ruling concluded that the Washington state law prohibiting assisted suicide was in violation of the Due Process clause of the US Constitution, as it found a liberty interest in controlling the time and manner of one's death. The AMA had filed an *amicus curiae* brief in this case and its arguments were discussed in the decision. The Court summarily dismissed the important ethical and practice principles of double effect in pain management as well as the critical distinction between the withholding or withdrawing life sustaining treatment versus physician-assisted suicide.

While the majority opinion dismisses "slippery slope" arguments, a dissenting judge writes that "[i]f physician-assisted suicide for mentally competent, terminally ill patients is made a constitutional right, voluntary euthanasia for weaker patients, unable to self-terminate, will soon follow. After voluntary euthanasia, it is but a short step to a 'substituted judgment' or 'best interests' analysis for terminally ill patients who have not expressed their constitutionally sanctioned desire to be dispatched from this world." The Washington State Attorney General has indicated that it will appeal the decision to the US Supreme Court, a plan fully supported by the AMA.

In the Second Circuit, the Court overturned a decision by a District Court and found New York State laws criminalizing physician-assisted suicide to be unconstitutional. This ruling is more narrowly drawn than the Ninth Circuit decision, as it did not find a constitutional right to assisted suicide. Rather, the Second Circuit found the laws in violation of the Equal Protection clause of the 14th Amendment. The Court's opinion stated that a physician's ability to withdraw life-sustaining treatment and the ability to administer life-ending measures should be considered as equivalent acts. Any distinction between the two, argued the Court, would deny competent, terminally ill patients who are not on life support the opportunity to end their lives. The AMA is pleased that the New York State Attorney General has announced plans to appeal this decision.

Both decisions are disturbing as they articulate constitutional support for the practice of physician-assisted suicide. Neither decision recognizes the vital clinical distinctions involved in end-of-life care, particularly the administration of pain medication and the use of life-sustaining

treatment. Additionally, the decisions counter the ethical requirements of the medical profession, asserting a necessary role for physicians in assisted suicide. The Courts also fail to bring some definition to the concept of a disease's "final stages" or the state of being "terminally ill." Ultimately, these definitions would be crucial in preventing abuse. The Courts also dismissed arguments about the potential social threats of assisted suicide to vulnerable patients in our current health care climate. The Ninth Circuit case is particularly disconcerting in its treatment of medical ethics as a simple matter for the courts to decide.

CONCLUSION

The movement for legally sanctioning physician-assisted suicide is a sign of society's failure to address the complex issues raised at the end of life. It is not a victory for personal rights. We are equipped with the tools to effectively manage end-of-life pain and to offer terminally ill patients dignity and to add value to their remaining time. As the voice of the medical profession, the AMA offers its capability to coordinate multidisciplinary discourse on end-of-life issues, for it is essential to coordinate medical educators, patients, advocacy organizations, allied health professionals and the counseling and pastoral professions to reach a comprehensive solution to these challenging issues. Our response should be a better informed medical profession and public, working together to preserve fundamental human values at the end of life.

2.211 Physician Assisted Suicide. Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress — such as those suffering from a terminal, painful, debilitating illness — may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993. (*JAMA*. 1992; 267: 2229-2233)

Journal 1992 Discusses the right of competent, incurably ill patients to commit suicide. Examines the history of the right an individual has over his or her own body, and how the right to commit suicide has evolved from that concept. Emphasizes the *Cruzan* decision. Concludes that the right of an incurably ill person to commit suicide is a personal issue to be decided outside of the judicial system. References Opinions 2.21 and 2.211. Morgan, Marks, & Harty-Golder, *The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide?*, 57 *Mo. L. Rev.* 1, 44, 45 (1992).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 48-I-95

Subject: Quality Care at the End of Life

Presented by: P. John Seward, MD, MD, Chair

Referred to: Reference Committee G
(T.J. Castele, MD, Chair)

- 1 As an outgrowth of the previously constituted Inter-Council Task Force on Physician Assisted
2 Suicide, the Board of Trustees extended and redirected the Task Force, now the Inter-Council
3 Task Force on Quality Care at the End of Life, and asked it to develop potential actions to
4 respond to issues relating to care of marginal value. The Inter-Council Task Force, which
5 consists of members from the Board of Trustees, the Council on Ethical and Judicial Affairs,
6 the Council on Legislation, the Council on Medical Service, the Council on Medical Education,
7 and the Council on Scientific Affairs, agreed at the outset that the American Medical Association
8 (AMA) has a responsibility to exert and maintain a leadership role in addressing these
9 issues.
- 10
- 11 The Task Force's wide-ranging expertise enabled it to consider the broad implications of the
12 issues before it and present an achievable action agenda whereby the medical profession will
13 continue to exert a leadership role in assuring that the health and medical care our patients
14 receive is both beneficial and of high quality. The Task Force consulted with acknowledged
15 experts, including representatives from within the Federation, and reviewed and discussed
16 AMA Policy as well as policy received from numerous Specialty and State Medical Societies.
- 17
- 18 In assessing its responsibilities, the Task Force observed that isolating recurring situations
19 where the provision of treatment could be deemed to be futile or marginal would be very
20 difficult in light of care being provided to address the unique health and medical needs
21 presented by individual patients. For example, even where the care provided is outside a well-
22 established practice parameter, there is no dispute that the care still may be appropriate based
23 on the singular situation at hand. At this time, with the clear exception of care provided as a
24 patient is nearing the end of life, physicians and society have a limited ability to identify
25 situations where a substantial volume of the treatment provided for a given circumstance may
26 be readily characterized as marginal. The Task Force concluded that its most effective avenue
27 would be to concentrate on treatment that is provided patients nearing the end of life, and to
28 develop an agenda for future action on the broader issue of marginal care.
- 29
- 30 Physicians are schooled to provide medical interventions and direct health care services that
31 will extend and/or improve the quality of life. For patients at the end of life, which may
32 encompass the very small neonate, a young accident victim, sufferers of debilitating illness at
33 midlife, and the eldest members of our society, the focus of care frequently shifts to palliation

1 and quality of life becomes the predominant consideration for decisions made within the
2 patient/physician relationship. The immediate goal of the Task Force is to aid physicians in
3 identifying when in the care-giving process this transition in care needs may occur, and to
4 identify practical actions that can be taken to improve the quality of life for those facing the end
5 of life.

6
7 The need to achieve this goal was underscored by the recent Robert Wood Johnson Foundation
8 study published in the November 22/29, 1995, issue of the Journal of the American Medical
9 Association: A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The
10 Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUP-
11 PORT). One of the findings from SUPPORT was that physicians were not being as responsive
12 as they should be to the needs of their patients at the end of life. This study concludes that
13 greater individual and societal commitment and more proactive and forceful measures may be
14 needed to improve the experiences of seriously ill and dying patients. The Board and the Task
15 Force concur with this conclusion. Indeed, this was a factor recognized by both the Task Force
16 and the Board last summer when the Task Force refocused its attention to concentrate on
17 quality care at the end of life. This report and the proposed future agenda is an outgrowth of
18 the identified need to address this issue.

19
20 The future agenda will require considerable oversight and support from the Board and from
21 various elements of the AMA: the Council on Medical Service and the Council on Scientific
22 Affairs will have major roles in setting directions for care, and defining and updating param-
23 eters relating to limits on treatment abilities; the Council on Medical Education will need to
24 continue seeking improvements in physicians' educational curricula; the Council on Ethical and
25 Judicial Affairs will again have to wrestle with the definition of "futility;" the Council on
26 Legislation will have to monitor and direct action on various legislative initiatives; and the
27 Organized Medical Staff Section and the Alliance will be just two of the other entities involved
28 in implementation efforts.

30 Ethical Considerations

31
32 End of life issues, including personal autonomy, beneficence, and quality of life, have always
33 been entrenched in prominent societal values and ethical principles. Through their close
34 relationships with their patients, physicians continue to play a significant role in how people
35 address these issues. Through their ability and based on an evolving and expanding armamen-
36 tarium, the physicians of today are deeply involved with the highly personal issues people face
37 at the end of life. Moral consideration of these issues has intensified considerably in recent
38 decades with the advent of far more effective life-sustaining technologies, diagnostic advances,
39 and the increasing challenge of allocating scarce resources.

40
41 To help address the multiple near-death responsibilities within the patient/physician relationship,
42 Medicine's Code of Medical Ethics addresses this interface. The patient's power to control his
43 or her own body and life is both bolstered and safeguarded by existing ethics policy; patients
44 more often assume control of their medical decisions, with the requirement of informed consent
45 to treatment firmly in place. This is the first principle of medical ethics and must be honored
46 by the physician, even where the physician or family member would decide differently if it was
47 his or her body. As the Council on Ethical and Judicial Affairs (CEJA) has stated: "The
48 patient has the right to make decisions regarding the health care that is recommended by his or

her physician. Accordingly, patients may accept or refuse any recommended medical treatment." (CEJA Report A-90; updated A-94)

Confronted with several high-profile court cases involving withdrawal of life-sustaining treatment (e.g. Wanglie, Cruzan and Baby Doe) and recognizing the increasing number of people dying in hospitals with the multiple questions presented from the availability of technologic support, however, CEJA has considered several aspects of terminal care.

Withholding and Withdrawing Life-Sustaining Medical Treatment - CEJA Opinion 2.20 defines "life-sustaining treatment" as any medical treatment that serves to prolong life without reversing the underlying condition, including ventilation, dialysis, artificial nutrition and hydration, chemotherapy, and antibiotics. The Opinion states that there is no ethical distinction between withholding or withdrawing treatment. Consistent with the established roles within the patient/physician relationship, the Opinion notes that the right to decide about life-sustaining therapy is highly individual and lies directly with the competent patient. Where the patient is not competent and where there is no advance directive, such as may occur with a very young child or an unconscious or otherwise incompetent adult, a family member or other surrogate may act for the patient in a proxy situation.

Assuming the patient does not misunderstand the prognosis and treatment options and is not suffering from a treatable form of depression, physicians generally are morally obligated to abide by the competent patient's directions in the provision or withdrawal of life-sustaining treatment. Regardless of a patient's decision, patients should be reassured that every effort will be made to preserve comfort and dignity. Opinion 2.20 (which also discusses surrogate decision-making) contains the following relevant statements:

A competent, adult patient may, in advance, formulate and provide a valid consent to withholding or withdrawal of life-support systems in the event the injury or illness renders that individual incompetent to make such a decision.

Physicians have an obligation to relieve pain and suffering and to promote dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.

Ideally, a patient should have an advance directive which both appoints a proxy for health care decisions and outlines his or her wishes on life-sustaining treatment options. As an adjunct to an advance directive, goals of care (such as could be documented in a values history section of the medical record) should be discussed in the course of the patient-physician relationship and with family care givers if appropriate.

Futile Treatment

In addressing end of life care decisions, physicians must also determine whether potential treatment will be beneficial or futile given the patient's clinical condition and prognosis. CEJA

Opinion 2.035 states:

Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefitting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in opinions 2.03 (Allocation of Limited Medical Resources) and 2.095 (Provision of Adequate Health Care), not on the concept of "futility," which cannot be meaningfully defined. (Emphasis added.)

While futility rationales are purportedly founded on clinical experience and accepted standards of care, they also are based frequently on the physician's subjective assessment of the patient's quality of life, which may or may not be in harmony with the patient's own conception.

In looking to Opinions 2.03 and 2.095 for guidance, Opinion 2.095 sets out the following five ethical criteria that should be considered "in determining whether particular procedures or treatments should be included in the adequate level of health care:

- (1) degree of benefit (the difference in outcome between treatment and no treatment),
- (2) likelihood of benefit, (3) duration of benefit, (4) cost, and (5) number of people who will benefit (referring to the fact that a treatment may benefit the patient and others who come into contact with the patient, as with a vaccination or antimicrobial drug)."

Opinion 2.03 addresses criterion number four, the reality of limited resources, and underscores physicians' patient advocacy role:

The treating physician must remain a patient advocate and therefore should not make allocation decisions. Patients denied access to resources have the right to be informed of the reasoning behind the decision. The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

In each instance where a medical determination results in resource allocation repercussions, physicians have to make responsible decisions guided by accepted ethical criteria. Such decisions should be based on considerations such as the likelihood and duration of benefit, the urgency of the patient's condition, and in some cases the effect of using limited resources necessary for successful treatment. This last factor reflects the significant societal implications of end of life decisions, and the implicit rationing which occurs. Patient therapies not predicted to maintain an acceptable quality of life may result in intensive care beds, renal dialysis slots, and other essential care being unavailable for others.

To aid physicians and patients, Medicine has a responsibility to focus more narrowly on the point in the care continuum where further treatment may be portrayed as being futile and medically inappropriate. Such a determination, which realistically is not a solo decision, can be guided by an understanding of a working concept of futility that can serve as a baseline for decision making within the context of the patient/physician relationship. Recognizing that the definition would have to be applied in real patient care situations, the Task Force is convinced that the concept of a working definition is highly important. The Task Force believes that

society must recognize the limitations of medicine and that physicians should not be placed in situations where they must provide treatment that will not achieve physiological benefits for their patients. The Task Force believes that CEJA has an on-going responsibility to develop an initial working definition of futility and to periodically reconsider the concept.

In facing end of life decisions, physicians individually will have to resolve how they will address potential conflicts with patients and their families where intensive care is demanded and the physician does not believe such treatment has a reasonable chance of benefitting the patient. Even though Opinion 2.035 says that "patients should not be given treatments simply because they demand them," conflicts still may arise. This fact was confirmed by the Robert Wood Johnson Foundation study noted above. While such questions are settled under ethical principles, the existence of ethical standards does not preclude legal action and the liability concerns physicians may have.

An April, 1995 lawsuit in Massachusetts appears to have been the first to test whether a doctor must provide treatment that a patient (or surrogate decision maker) has requested, even though the doctor believes that the care would be futile. The case, Gilgunn v. Mass General, involved an elderly woman who became comatose and suffered irreversible neurological damage while a patient at Massachusetts General Hospital (there were no allegations that either the hospital or the physicians involved in the care were responsible for this health status). Doctors at the hospital issued a "do-not-resuscitate (DNR) order" over the objections of the woman's daughter who claimed that her mother had always wanted everything medically possible to be done for her should she become incompetent. In their decision-making process, the hospital and the medical staff adhered to an established policy that ultimately bolstered their case. Under this policy, the attending physicians sought consultation by the ethics committee and the hospital's legal counsel at appropriate junctures when life-sustaining treatment decisions were pending. Nevertheless, the daughter filed a lawsuit asserting that the doctors were obligated to abide by her mother's wishes that she be kept alive as long as possible.

After deliberating for two hours, the jury found the hospital and two of its doctors not guilty of negligence or of imposing emotional distress on the daughter. In an interview after the verdict was announced, the hospital's lawyer stated that the verdict indicated that "in very rare instances, particularly in situations at the end of life, where medicine simply cannot hold off death, that physicians can't be required to do things that they feel would be inappropriate and harmful to the patient." If the court had ruled in favor of the daughter, every doctor and every hospital would be reconsidering whether they have to provide every treatment a patient demands. While an appeal is pending, its success would be contrary to a relatively settled area of law. Reflecting the fact that courts generally defer to the judgment of physicians in resolving medical questions, no physician in this century in the United States has been found liable or guilty in a civil or criminal proceeding for ramifications resulting from withholding or withdrawing life-sustaining treatment from any patient.

Legislative solutions have been proposed in some states aimed at protecting physicians and others involved in care situations similar to the Gilgunn case. In addition, legislation has been introduced to protect physicians from disciplinary actions for prescribing or administering controlled substances for people with intractable pain. These and related legislative proposals and state laws need to be monitored and compiled, and the Council on Legislation should continue to advise the Board on such matters.

Education

Even with increasing emphasis on issues relating to death in the curricula of medical schools and residency programs, many physicians are not adequately educated about the treatment directions and options available in caring for dying patients. Association policy is clear in calling for medical students and physicians-in-training to be better apprised of treatment options they might offer to their patients at the end of life. This issue was discussed by the House of Delegates one year ago when the Council on Medical Education's report, "End of Life Care," was adopted (CME Report 4, I-94). This report went into great depth in: (1) discussing the need for more focused educational experiences relating to care for dying patients; (2) discussing AMA policies and activities relating to palliative and other care issues relating to care for dying patients; and (3) recommending continued cooperative activities in evaluating and developing palliative medicine curriculum materials and textbooks for medical schools as well as for resident and practicing physicians.

Going one step further, the Task Force believes that practical information and experience on care for dying patients must be integrated into medical education curricula, and that these issues must be discussed in both clinical and ethical contexts. While informed consent, patient autonomy and endstage case studies are broadly discussed in ethics courses and pain management strategies are addressed in clinical rounds, the necessary integration of care options for dying patients, including the role of hospice care, into ethical curricula and medical education in general is essential to producing optimal patient care for the future.

Physicians need a better understanding of treatment and care options, and should be instructed on collaborative decision-making within the health care team, and with the patient and the patient's family. For example, continuing medical education programs should be developed to increase awareness of hospice concepts, and physician organizations and other entities should concentrate on public education programs within the local community. An example of a physician initiated program that was instituted at the local level and that is gaining interest across the nation is GUIDe, Guidelines for the Use of Intensive care in Denver. GUIDe and other local activities are consistent with the reality that an essential cornerstone for education relating to end of life care must be a full understanding of the role of an advance directive in care decisions.

Advance Directives

Existing AMA Policy supports the use of advance directives and it identifies a physician role in their use. A review of Medicine's ethical standards relating to care for patients at the end of life also clearly indicates that it is the patient's directions, even in the form of an advance directive, that should set the course for treatment. Our House of Delegates specifically acknowledged this at the 1993 Annual Meeting when it adopted Policy 140.953(6), AMA Policy Compendium: "Patients should discuss end of life decisions with their physicians and make their wishes known. Such a discussion might include writing an advance directive."

Physicians should initiate a discussion on goals of care and advance directives as part of the routine patient history. In particular, there should be such a discussion with all elderly patients and patients with chronic or terminal illnesses. Such a discussion should go beyond a mere inquiry as to whether the patient has executed an advance directive, and it should focus on why

1 an advance directive should be considered and the physician should be able to respond to
2 questions and provide back-up information.

3
4 While Ethical Opinions are articulate and well supported by AMA policy on the value and need
5 for patient directions to guide care at the end of life, day-to-day experience repeatedly demon-
6 strates that far too many situations occur where the physician and other members of the patient
7 care team have no indication of how the patient would like to proceed when facing care
8 decisions near the end of life. The AMA has a number of policies (which should be the subject
9 of a consolidation report) that speak to the physician's role as an involved party in his or her
10 patient's consideration of an advance directive. The potential role follows in one of two
11 directions: as a provider of the actual form or specific information on advance directives; and
12 as a resource to respond to patient inquiries. Specifically, AMA Policy sets the following
13 directions:

- 14 • Policy 85.968 encourages physicians and their patients to execute an advance directive;
- 15 • Policy 85.972 calls on physicians to promote advance directives;
- 16 • Policy 140.953 calls on physicians to participate in patient discussions on end of life
- 17 decisions, including an advance directive;
- 18 • Policy 140.969 calls on physicians to educate their patients on the use of advance
- 19 directives;
- 20 • Policy 140.970 discusses the role of the health care facilities in establishing advance
- 21 directive protocols;
- 22 • Policy 140.976 encourages physicians to have information about advance directives
- 23 available in their reception areas;
- 24 • Policy 140.985 calls for physicians to encourage their patients to use advance direc-
- 25 tives; and
- 26 • Policy 140.989 calls for sufficient information to be contained in patient records to
- 27 enable another health care professional to avoid unnecessary or inappropriate tests or
- 28 therapy.

29
30
31 Even with this policy and ethical history supporting patient direction of care decisions at the
32 end of life, bed-side reality is that the physician and family members frequently are left to
33 guess at what care options the patient would elect. According to an August 1995 Government
34 Accounting Office Report (GAO/HEHS-95-135), Patient Self-Determination Act - Providers
35 Offer Information on Advance Directives but Effectiveness Uncertain:

36
37 We also found that advance directives have been advocated more than they have been
38 used. Surveys indicated that, in general, only 10 to 25 percent of Americans have
39 documented their end-of-life choices or appointed a health care agent. Lack of commu-
40 nication between patients and physicians and misunderstandings about appropriateness
41 and purpose of advance directives may explain why completion rates remain low.

1 This information is consistent with an AMA survey, released in October, 1995, which found
2 that three-fourths of Americans believe living wills are important, but that more than two-thirds
3 do not have one.

4
5 To increase understanding and use of advance directives, the Task Force is convinced that the
6 AMA and individual physicians need to take a more vocal leadership position. Because
7 leadership truly begins on our front door steps, Delegates and Alternate Delegates to this House
8 are urged to go back to their home towns and act as advocates for the use and utility of advance
9 directives with both their patients and their colleagues, and within their own families.

10

11 Physicians, and physician leaders in particular, should be familiar with the patient guide jointly
12 released on October 1, 1995 by the AMA, the American Association of Retired Persons
13 (AARP), and the American Bar Association (ABA): Shape Your Health Care Future with
14 Health Care Advance Directives. This guide combines a living will and health care power of
15 attorney into a single, comprehensive advance directive that is designed to be portable to fulfill
16 requirements under most state laws. Finally, the Task Force believes that the Council on
17 Legislation should re-examine the Patient Self-Determination Act¹ to determine whether an
18 explicit physician role relating to distribution of advance directive information should be
19 incorporated into the law.

20

21 It also must be noted that advance directives need not be written. Reliable statements by
22 patients made when they were competent can serve as ethically and legally valid representations
23 of their wishes, and spoken expressions may suffice. When a patient has left no written
24 directive and there is no reliable evidence of a spoken expression, the appropriate representa-
25 tive, as determined by state law, may serve as a surrogate. It is not the surrogate's role to
26 advance his or her own wishes, but to make the best approximation of what the patient would
27 have wanted under the circumstances. Finally, it is increasingly recognized that children can
28 and should participate in decisions about their own health care, including terminal care. As
29 adolescents begin to resemble adults in their capacity to understand the consequences of
30 alternative approaches, their desires should play a larger role. Age alone should not be the
31 determinant of how much influence the patient's wishes should play in treatment decisions.
32 When the child cannot participate in decisions, as in infancy or severe retardation, parents

¹Section 1866 of the Social Security Act, as amended by OBRA-90, requires hospitals, skilled nursing facilities, home health agencies, Medicare HMOs, and hospices (providers) to maintain written policies and procedures regarding advance directives for their adult patients as a condition of Medicare participation. The law does not preempt state law allowing health care providers to conscientiously object to the implementation of advance directives. Providers are prohibited from conditioning admission or otherwise discriminating on the basis of the presence or absence of an advance directive. The law specifies that providers must: (1) furnish written information to each patient upon admission to their facility, or upon coming under the care of the agency, or upon enrollment in an eligible organization concerning the patient's rights under state law (either statutory or case law) to make decisions such as the acceptance or refusal of treatment and the right to formulate an advance directive, and the provider's policies regarding implementation of these rights; (2) document in the medical record whether or not the patient has an advance directive; (3) ensure compliance with state law regarding advance directives; and (4) provide education for staff and the community on issues concerning advance directives.

generally should be presumed to be appropriate representatives and acting in the child's interest. When a parent appears to be acting unreasonably, the physician must be prepared to challenge this authority and legal action may be necessary.

Palliative Care

For many physicians, the continuum of care provided in the course of the patient/physician relationship includes care for patients who are dying. For some physicians, this is part of their routine, and for others it is an occasional experience. Dealing with inevitable death does not reflect professional failure, and physicians must recognize that such moments are one of the greatest and most complex challenges in the patient/physician relationship and that medical attention and emotional support at such times are vital. One of the many individual aspects of care for the dying patient is understanding when the focus of treatment should shift from efforts to extend and/or improve the quality of life to palliation where quality of life is the predominant consideration. Part of this process will require a more clear understanding of when it may be said that a patient is dying. It must be better understood that people with illnesses other than those routinely recognized as terminal, such as advanced cancer and AIDS, also may be facing the end of life. Physicians, as well as patients and their families, must recognize that patients with a progressive illness that is expected to end in death and for which there is no treatment that can substantially alter the outcome, such as severe congestive heart failure, also should be identified as potentially benefitting from palliative care.

The American Geriatrics Society's (AGS) Position Statement, The Care of Dying Patients, is instructive:

Dying is the final portion of the life cycle for all of us. Providing excellent, humane care to patients near the end of life, when curative means are either no longer possible or no longer desired by the patient, is an essential part of medicine. The AGS recognizes that most people near the end of life desire and should be able to obtain attentive care directed at relieving symptoms, maximizing comfort, and maintaining dignity and control.

The AGS Statement presents three patient care issue positions relating to care for imminently dying patients:

- The care of the dying patient, like all medical care, should be guided by the values and preferences of the individual patient.
- Palliative care of dying patients is an interdisciplinary undertaking that should attend to the needs of both patient and family. (Within the context of this statement, the AGS defines the term "palliative care" or "comfort care" as "care directed toward the quality of life of patients who are dying, including the relief of pain and other symptoms, attention to the psychological and spiritual needs of the patient, and providing support for the dying patient and the patient's family.")
- Care for dying patients should focus on the relief of symptoms, not limited to pain, and should be addressed by both pharmacologic and nonpharmacologic means.

1 The Task Force and the Board concur with the AGS Position Statement and finds it consistent
2 with the recommendation in CEJA's 1991 Report, Decisions Near the End of Life:

3
4 Physicians have an ethical obligation to relieve pain and suffering and to promote the
5 dignity and autonomy of dying patients in their care. This includes providing effective
6 palliative treatment even though it may foreseeably hasten death.
7

8 Physicians are ethically and professionally obligated to provide optimal palliative care to dying
9 patients. However, there are several barriers to meeting this goal, including:

- 10
11 • Lack of adequate information about pain medication appropriateness, including dose
12 frequency;
- 13
14 • Unnecessary concerns about addiction to pain relievers;
- 15
16 • Overzealous Drug Enforcement Agency (DEA) oversight based on the amount of pallia-
17 tive therapy physicians prescribe; and
- 18
19 • Concerns over the potential "double effect" of analgesics, where optimal pain manage-
20 ment also may have the corresponding impact of hastening death, even though the
21 intent is to relieve pain and suffering.
22

23 Ethical directions are clear that palliative care may be the care of choice even where it may
24 hasten death. To enhance the movement toward more effective use of palliation as a means to
25 assure a better quality of life for those at the end of life hinges largely on better education in
26 both the physician and patient communities. Physicians need a better understanding of their
27 responsibilities in providing and directing care for a dying patient, and patients need a better
28 understanding of their responsibilities in directing the care they receive. With improved
29 understanding of the use and benefits of palliative care by physicians, other health care
30 professionals, the public and government regulatory agencies, concerns over matters such as
31 DEA oversight will be diminished as the use of various medication regimens for dying patients
32 becomes more expected and accepted.
33

34 Physicians and patients also need a better understanding of what constitutes palliative care and
35 when this type of treatment course should be considered. As a starting point, the Councils on
36 Medical Service and Scientific Affairs should investigate the development of parameters for
37 palliative care. Finally, there is an important educational role that must be fulfilled if physi-
38 cians and the public are to understand both the concept of palliative care and when palliative
39 treatment may be the care of choice. Looking to the fact that palliative care needs will change
40 depending on the underlying medical condition, there should be a major role for Specialty
41 Medical Societies in educating their members regarding palliative treatment options. Public
42 education campaigns may be more effective if handled locally, as exemplified by the activity of
43 GUIDe, the San Diego County Medical Society, and the Alliance, and they may be developed
44 and maintained by various elements within the Federation.

1 Medicare and Medicaid Coverage

2
3 **Current Law** - A significant portion of end of life care is provided under Medicare and
4 Medicaid, with estimates showing that Medicare and Medicaid beneficiaries account for 65% of
5 all deaths that occur each year in the United States. Based on the patient populations served by
6 Medicare and Medicaid, the elderly, the disabled, the poor, and the bulk of the nation's nursing
7 home patients, this is not surprising.

8
9 Medicare's response for dealing with end of life care issues have included improved informa-
10 tion on advance directives and creation of and then expansion of the hospice benefit. Under
11 this benefit, a patient who is certified by a physician as having a terminal illness with life
12 expectancy of six months or less is eligible for the hospice benefit where palliative care is
13 provided along with support programs and assistance to the patient and family. Federal law
14 regarding advance directives requires hospitals, nursing homes and HMOs to provide relevant
15 information to beneficiaries. Under Medicaid, hospice care is an optional benefit that states
16 may include in their benefit package.

17
18 Even with nearly 180,000 hospice patients in 1994 being Medicare and Medicaid beneficiaries,
19 end of life care for most Medicare and Medicaid patients is provided in hospitals. Under
20 Medicare, hospital coverage is provided through the prospective pricing system based on the
21 appropriate Diagnosis Related Group (DRG) payment amount. HCFA has announced that it is
22 working with the Milbank Memorial Fund to explore the possibility of establishing a DRG for
23 hospital inpatient care services relating to palliative care for a "final" illness. Consistent with
24 this direction, the Current Procedural Terminology (CPT) Editorial Panel should be asked to
25 consider the potential for development of CPT codes to identify physician services for palliative
26 care.

27
28 **Transformed Medicare and Medicaid** - Under pending legislation to transform both Medicare
29 and Medicaid (opening the Medicare program to more marketplace involvement and use of
30 private sector health insurance and other types of health benefits plans, and changing Medicaid
31 into a block grant program with states receiving increased flexibility for program operation in
32 exchange for less federal money) payment policy regarding palliative and end of life care will
33 not carry as much weight as it does now with two national programs that cover nearly 70
34 million Americans. For example, even if HCFA develops a DRG for palliative care related to
35 terminal illness, it would only apply to inpatient hospital services for patients who remain in
36 traditional Medicare and to enrollees in plans that choose to follow Federal policy. This is one
37 of the reasons why a CPT code for the related physician services would be desirable.

38
39 On the matter of advance directives, the Medicare proposal approved by the House and Senate
40 prior to the Thanksgiving holiday (part of the 1995 Budget Reconciliation bill) would require
41 plans operating under the proposed MedicarePlus program to provide advance directive
42 information to enrolling beneficiaries.

Euthanasia and Physician Assisted Suicide

Medicine's Ethical Opinions leave no question in addressing euthanasia and physician assisted suicide. Opinion 2.21 addresses the issue of euthanasia and Opinion 2.211 addresses the issue of physician assisted suicide, stating:

2.21 Euthanasia - Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

2.211 Physician Assisted Suicide - Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

While competent patients generally retain autonomy in end of life decisions, this does not extend to requests for euthanasia or physician assisted suicide. Euthanasia (the direct administration of a lethal agent with the intent to hasten death) and physician assisted suicide (the provision of the means or information to kill oneself where the intent in providing the information is to aid the patient in committing a suicidal act) are both ethically prohibited. Dire social implications are inherent in the issues of euthanasia and physician assisted suicide, because such practices pose a serious risk of abuse that is virtually uncontrollable. It is particularly important that physicians not engage in such practices, which are fundamentally inconsistent with the physician's role as healer and could contribute to erosion of the patient/physician relationship.

Calls for legalization of physician assisted suicide and euthanasia point to health care needs that the public perceives are not being met. The profession does not deny the extreme duress suffered by some patients. However, these patients' needs can perhaps be better met by attentive care givers, flexible in their treatment regimens, liberal with palliative care, and generous with spiritual and emotional support. Alternative treatment options, including enrollment in hospice programs, should be considered. A thorough study of clinical situations precipitating requests for euthanasia would be helpful in identifying unmet needs in end of life care.

Physicians face a paradox where patients may seek to end their lives and where action to support this goal is inconsistent with the physician's role. In addressing this, physicians have a responsibility to acknowledge their limitations and to aid their patients by providing effective palliative care and by coordinating resources available in the community, including hospice care, to assist in end of life care. Patients and their families need to be given a clear understanding of their responsibility to direct care, including information on advance directives, and the availability and low addictive potential of potent analgesics.

Conclusion

Modern medicine's most difficult ethical predicament is deciding when it is no longer humane or justifiable to artificially sustain a patient's life. Even Hippocrates advised physicians "to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless." This report attempts to balance this ultimate paradox between the advances of technology and medicine and the limits of life itself. In addressing this paradox, there is little question that quality of care should be and can be improved for patients at the end of life. Physicians have an ethical and professional duty to provide the most effective treatment and care for their patients, and physicians will not shirk from this responsibility.

Improving quality care at the end of life must start with communication. Effective communication is an important theme and goal reiterated throughout ethical opinions and related policies associated with end of life care. Patients deserve full information about their clinical status, honest assessment of prognosis, and education about potential treatment options. Patients should be told of their right to refuse treatment, including DNR orders, especially if the treatment involved is burdensome and may be deemed by some to be futile or of marginal value. Patients should also be instructed about life-sustaining treatments they may opt for if it becomes necessary. Physicians should encourage patients to consider their attitudes about health care and quality of life prior to a crisis, advocating completion of advance directives. Finally, patients who decide to end aggressive therapy should be fully informed about alternative avenues for care, including various palliative efforts, pastoral care and hospice.

Perhaps just as important as informing critically ill patients is listening to them. By learning the patients' wishes in the course of care, a physician can be helpful in identifying the best therapeutic or palliative interventions. Comfort care can be optimized by ongoing assessment of a patient's discomforts and needs. Physical presence of a trusted physician can be an invaluable social, emotional and spiritual aid to a suffering patient.

Finally, physicians have a responsibility to take actions to assure and provide a future where the medical/health care environment, entrusted to provide care for patients at the end of life, will enhance decision making ability and allow for more effective decision making.

RECOMMENDATIONS

The Task Force and the Board of Trustees recommend that the following recommendations be adopted and that the remainder of this report be filed:

House of Delegates Action

1. That Delegates and Alternate Delegates attending this meeting, as well as those attending future meetings, be urged to complete (if this has not already been done) a health care advance directive such as the one jointly developed by the AMA, AARP, and the ABA and provided in the Delegates' information packet; that said Delegates discuss their own directives with their families; and that they advocate the completion of such directives by their families, patients, and colleagues;

2. That the AMA complete a Policy Consolidation of AMA Policy relating to end of life issues, including the use of advance directives, for consideration at the 1996 Interim Meeting.

Council Action

3. That the Council on Legislation re-examine the Patient Self-Determination Act and related state laws to determine whether there is an appropriate physician role that should be incorporated into the law relating to physician responsibility in the distribution of advance directive information and their use in pre-hospital, hospital, and post-hospital settings;

4. That the Council on Legislation complete status reports on state legislation relating to both protecting physicians and other care givers in instances where appropriately issued orders to end treatment or issue a DNR order are contrary to the directions of a surrogate decision maker, and protecting physicians from disciplinary actions for prescribing or administering controlled substances for people in intractable pain, and for the Council to develop, as appropriate, model legislation on these matters;

5. That the Council on Ethical and Judicial Affairs work to develop an initial working definition of "futility," based on the concept that physicians should not be placed in situations where they must provide treatment that will not achieve physiological benefits for their patients, and to periodically reconsider this working definition;

6. That the Council on Medical Education, for consideration at the 1996 Interim Meeting, provide a follow-up report on implementation of CME Report 4, I-94, with this report also addressing physician, resident physician and medical student education (ethical and clinical curricula, and textbooks) on end of life care, coordination of hospice centered care, palliative care, pain management, and meeting the needs of terminally ill patients;

7. That the AMA, through the Councils on Medical Service and Scientific Affairs, investigate the development of practice parameters for palliative care;

8. That the AMA, through the Councils on Medical Service and Scientific Affairs, examine the potential of incorporating within existing and developing practice parameters a process to identify and measure when a treatment option may provide only a limited benefit for the patient;

Federation Action

9. That the AMA request the CPT Editorial Panel to consider the development of a code or codes to reflect the provision of palliative care and related consultative services;

10. That the AMA, through a Federation outreach process, conduct a study of clinical situations precipitating requests for euthanasia;

11. That the Organized Medical Staff Section ascertain the status and use of interdisciplinary ethics committee in hospitals to address issues in providing end of life care, and the extent of physician involvement in these processes;

12. That the Organized Medical Staff Section encourage the medical staff of every hospital to adopt a working definition of "futility" in their environment based on CEJA's definition and develop guidelines or parameters about its use and implementation in end of life care;

Policy Action

13. That the AMA continue to oppose euthanasia and physician assisted suicide as fundamentally inconsistent with the physician's role, recognizing that such practices could contribute to erosion of the patient/physician relationship, and that the AMA assist state medical societies in actively opposing ballot and legislative measures to allow these practices;

14. That the AMA work with the Drug Enforcement Administration and the Federation of State Medical Boards to foster a better understanding of the legal and proper role of pain medication in the provision of palliative care;

15. That the AMA continue to conduct research and compile data on end of life issues and palliative care, including a study to identify characteristics of physicians who frequently provide such care;

Outreach Action

16. That the AMA communicate with health insurance entities and their representatives, including key managed care organizations, concerning their role in providing health care coverage for patients at the end of life and in working with physicians and other care givers at this juncture in the life of the patient;

17. That the AMA communicate with medical school deans and residency program directors concerning the importance of addressing in their ethical and clinical curricula issues related to quality care for patients who are dying;

18. That the AMA explore working in concert with and securing funding from appropriate public and private organizations, such as the American Institute of Life Threatening Illness and Loss, the Milbank Memorial Fund, the Robert Wood Johnson Foundation, the Hastings Institute, the Institute of Medicine, and others, to promote actions to enhance quality of care at the end of life;

19. That the AMA disseminate this report throughout the Federation with a request that it be distributed to local physicians and serve as the basis for organized discussions; and

20. That the AMA use all of its communications resources, including AMNews and JAMA, to initiate communications campaigns to better educate physicians, other health professionals, and the public on issues relating to quality care at the end of life, particularly the need to honor the wishes of patients as stated in their advance directives.

Mr. CANADY. Bishop Spong.

STATEMENT OF BISHOP JOHN S. SPONG, NEWARK, NJ

Bishop SPONG. Thank you, Mr. Chairman.

I have been pleased to learn through three panels today that the clergy are not the only profession who do not live within imposed time limits. We have lots of company. I thought we were maybe the only ones for a while.

There are two emotional pitfalls that stand ready to make the national debate on assisted suicide emotional and highly partisan. The first pitfall lies in the traditional definition of the word "suicide," which brings to mind an act of destruction associated with depression and mental illness. Religious voices through the ages have called this kind of suicide unnatural and even sinful, going so far as to refuse to perform burial services for suicide victims. The religious and political rhetoric reflecting these attitudes of the past now threatens to destroy the present debate with inappropriate hyperbole.

The second pitfall appears when the phrase "assisted suicide" becomes a pawn in the abortion debate. The connector is usually found in the phrase "the right to life." The morality of abortion is a worthy debate on which good and decent people hold deeply contrasting views, but to confuse assisted suicide with abortion is both inappropriate and misleading.

The major differences between the two are significant. In assisted suicide the choice to end one's life under certain circumstances takes place at the end of the life cycle, and it is a choice made by the affected person. Abortion occurs when the life of the fetus is still potential and is an action in which the subject is neither consulted nor given a choice. Assisted suicide and abortion are thus quite different.

The concept of assisted suicide is a peculiarly modern topic. It was all but inconceivable a century ago. One did not even discuss it. It is before us today because of human ingenuity. Advances in the practice of medicine and in the spectacular development of various medical technologies are the parents of this debate. Medical science has succeeded in so many areas. Pain is today capable of being relieved in remarkably effective ways. Many killing diseases have been conquered. Both the boundaries and the quality of life have been extended beyond anything our ancestors could have imagined.

These are remarkable achievements in which we can rightfully rejoice, but it is this very success that has created for us the dilemmas out of which the assisted suicide debate has arisen. For it is the skill of medical science that has enabled us to cross that mysterious boundary that separates the prolonging of life and good health from the ability simply to postpone death. We must recognize this subtle distinction. To enhance the length and beauty of life is clearly of value, but simply to prevent death is at best a questionable virtue.

We human beings now have arrived at a set of circumstances that requires us to embrace the freedom and to find the courage to decide for ourselves how long our life will be extended and under what circumstances our death shall occur. Once there was a neat

distinction, which has been referred to many times today between what many religious people call passive and active euthanasia. Passive euthanasia meant the refusal to take extraordinary means to extend life and was generally approved by traditional religious thinking. Active euthanasia meant taking an overt action to hasten death and was traditionally condemned by religious thinking. That distinction however has been rendered all but meaningless by the advances in modern medicine. Today decisions by doctors and family members to remove or not to remove life support systems and to assist or not in allowing nature the right to take its course, are daily occurrences in hospitals across this Nation.

That specter causes many people to seek the assurance that we will have some say in that moment of our life. Many of us want the moral and legal right to choose to die with our faculties intact, surrounded by those we love, before we are reduced to being breathing cadavers attended by strangers with no human dignity attached to our final days.

We are aware that life today can be prolonged by managing pain with pain-killing drugs; but that relief is sometimes achieved at the price of the destruction of the patient's mind or the loss of the patient's capacity to relate to other human beings in a meaningful way. Surely the prolongation of meaningless breathing is not a witness to the sacredness of life.

That is the situation out of which the demand arises for some legal means to preserve the individual's right to make an informed decision about the way he or she will die. Surely so personal a decision as this should not be dictated by the State. The legal right to die with dignity is an essential new modern freedom from which mature human beings must not shrink. Life cannot be identified with the extension of biological existence.

Another factor in this decisionmaking process arises from the incredible expense of terminal care. Obviously the value of life cannot be measured in economic terms alone, and economic considerations must never drive this debate. Yet when the options are clear, and a patient knows that he or she faces days, weeks, perhaps even a few months of expensive, pain-filled, not always conscious life, with no hope of a long-range cure, then at least I, as one citizen who is both a husband and a father, want to be given the right morally and legally to make that decision for myself. I want the ability to weigh the values of those additional days, weeks, or months of my existence against the costs that my family must pay both in terms of their financial resources and their emotional reserves. Because of the love I have for those closest to me, I want to be able to cast my vote for what is in their best interest, even if that means choosing a quicker end rather than allowing the inevitable lingering dissipation of my mind and body.

If one wants to look at the immorality of medical costs today, one should look at the rich capital gains being accrued to smart investors in HMO's and at those million dollar bonuses paid to the CEO's of major health care corporations.

Of course there are dangers when a society decides to allow its citizens this freedom of choice at the end of life. Convenience or greed in cooperation with a few unscrupulous members of the med-

ical profession do have the potential to create a world of horrors for many people. Those dangers, however, are not inevitable.

I suppose it would be quite impossible for all malfeasance to be eliminated from this area of life. Malfeasance has not been completely eliminated from any other area of human activity. I do suggest that this is, however, an excuse, and a poor one at that, when we assume that the same human brilliance that produced the miracle of modern medicine cannot solve the problem of prohibiting improper decisions while still allowing individuals the choice of how to live out their final days. When human beings have done an audacious thing, we ought not to tremble before the choices presented to us by our own audacity. Safeguards can be put into place. The slippery slope arguments against assisted suicide by those who fear every new possibility can be addressed.

Finally, I want to be clear, particularly since I have heard the religious argument referred to several times today, I want to be clear that I have come to these conclusions out of my Judeo-Christian faith tradition, and specifically as an Episcopal bishop. My personal creed asserts that every person is sacred, created in God's image, and of infinite value. I also believe we live in a country that endows its citizens with certain inalienable rights. Among those rights, newly given by modern technology as a peculiar gift of modern world, is the right to participate in the management of our own deaths.

Assisted suicide must never be a requirement, but it should always be a legal and moral option. This decision to end one's life needs to be faced openly, honestly, freely and in consultation with our loved ones, our doctors, and our spiritual advisers. When the decision on assisted suicide is made this way, I am convinced that it is a life-affirming, moral choice. It is also a human right, and I hope this Congress will grant it to the American people.

Thank you very much.

Mr. CANADY. Thank you, Bishop.

[The prepared statement of Bishop Spong follows:]

PREPARED STATEMENT OF BISHOP JOHN S. SPONG, NEWARK, NJ

What gives life its value? What gives life its meaning? If value and meaning are removed from life before life ceases to exist, is it then still life? Do potential value and potential meaning attach themselves to fetal life that is so embryonic as to be only potential, not actual? Who has the right to make decisions about life that is only potential? Is it the society? Is it the affected individuals or the bearer of that life? Does the sacredness ascribed by religious systems through the ages to human life reside in our biological processes? Is biological life itself sacred whether it be human or otherwise?

It is around these questions that debates swirl in this century on such ethical issues as euthanasia, assisted suicide, birth control, abortion, animal rights, the use of animal organs and parts in human attempts to combat diseases, vegetarianism and many environmental concerns. In most of these debates the emotional content is high. The person operates on the basis of an unstated but assumed answer to these questions that is passionately held. Frequently that answer is so deeply related to the core of the person's being that it allows no opposition. So the result is argument, not dialogue and heat, not light.

One of these issues is today coming before the society with increasing rapidity and it requires of the Christian Church a response. Is active, as well as passive, euthanasia an acceptable practice within the ethics of Christian people? To state it more boldly, is assisted suicide an ethical option for Christians and, if so, under what circumstances? At our Diocesan Convention this January this issue will be a major focus of our debate.

The first thing that must be noted is that these issues are peculiarly modern ones. A century ago and, in most cases, even fifty years ago, these issues would hardly ever have arisen. Throughout western history society in general and the medical profession in particular has been passionately dedicated to the preservation of life. The assumption commonly held was that life was sacred, that it bore the image of God and that its limits had been set by God. So deep was this conviction in the Judeo/Christian world, that murder was not only prohibited among members of the same tribe, but it was also surrounded by powerful disincentives. In the biblical code, when murder occurred, blood retribution was the legal right and moral duty of the victim's nearest of kin. To escape immediate vengeance and to determine whether or not extenuating circumstances existed, cities of refuge were set up for those who accidentally killed a fellow Jew. In these centers the killer could find temporary sanctuary until the case could be decided and the verdict rendered by the society. If the murder was in fact accidental, then innocence and thus freedom was established. But if not, then guilt and the delivery of the killer into the hands of the family of the victim could be pronounced.

Of course the killing of an enemy was not covered by this prohibition. Thus the Hebrew scriptures had no conflict in proclaiming that the same God who said, "You shall not kill" as part of the Ten Commandments could also order Saul to slay every "man, woman, infant and suckling," among the Amalekites (I Sam. 15:3). Even suicide was rare indeed in this religious tradition, so deep was their sense of the sacredness of life.

But in that world surgery was limited to the sawing off of a limb. Antibiotics were unknown. Blood transfusions could not be given. Organ transplants were inconceivable. Intravenous feeding was unheard of. Finally, machines or medicines that could stimulate the heart

and lungs could not be imagined. The time of death did seem to be in the hands of God. Human skill could do little to prolong it. So the idea grew and became deeply rooted in the psyche of the whole society that the sole task of medical science was to prolong life. That was a noble value then and it remains so today.

The realities of our world, however, have changed dramatically. That which was inconceivable, unimaginable and unheard of is now a part of our contemporary experience. We have extended the boundaries of life to where the values and definitions of yesterday collide with the technology and skill of today. That is why the debate on assisted suicide now looms before us and that is why this generation is driven to question the conclusions of the past.

Let me pose the complexities of this issue by asking a series of questions. In what does the sanctity of life reside? Is life sacred when pain is intense and incurable? Is it a value to drug a patient into insensibility for pain while continuing to keep him or her alive biologically? At what point does the quality of life outweigh the value found in the quantity of life? Is life's meaning found in the physical activities of the body or in the relationships that interact with the person whose physical body is alive? If those relationships can no longer exist, should the body be allowed to continue functioning? Who should make the life and death decisions in this world? Should that power be given to doctors? But doctors today are less and less involved with patients as medicine becomes more and more impersonal and complex. Since doctors still profit from hospital visits to their patients, we must recognize that there is a financial incentive to doctors to keep lingering patients alive. Should this decision be left to the family members? But there are cases in which family members have profited from the death of a relative. Family members have been known to kill a parent or a spouse when they had a vested interest in that person's demise.

Should that decision then be left to chaplains, rabbis, pastors or priests? But the religious institutions today are too weak to carry such a responsibility, since perhaps half of the population of our nation is today not related to any religious institution. It might also need to be said that even members of this professional group of "God bearers" have not always been strangers to self-serving corruption. Can the decision be left to the individual involved? Certainly that person needs to be involved in that decision if at all possible, but can it be solely the decision of one person? Should extraordinary care for terminally ill persons be allowed to bankrupt families? Where is the point where such care becomes destructive to the economic well being of the remaining family members? Because this generation is now capable of certain procedures, is there some moral necessity to use those procedures? Given the interdependence today of the health of the whole society through insurance rates, Medicare and Medicaid, extraordinary measures to prolong life universally applied would bankrupt the whole nation. Already this nation spends more than 80 cents of every health care dollar in the last year of the person's life. Should such life supports then be available only to those who can afford them? Would we then be equating the sacredness of life and the values that grow out of that concept with wealth? If health care has to be rationed, as it increasingly is in the managed care contracts, on what basis are extraordinary procedures to be withheld?

The values of yesterday are colliding with the technological and medical expertise of today, rendering the conclusions of the past inoperative for the future. That is why questions abound and debate rages around the issues of life and death at both ends of life's spectrum. Even the word "murder" is being redefined in this debate. Is a doctor who performs an abortion a murderer? Is Dr. Jack Kevorkian a murderer? Should he be prosecuted for assisting people into

death when hope for those persons had expired? Is it murder for a father who can no longer bear to see his child in intense pain or lingering malaise when all conscious function has been lost, to take matters into his own hands? Is it murder for a wife of long years to order no further food to be given to her dying husband in order to speed his death? Would it be different if she placed a plastic bag over his head to make the ending of life more dramatic? Would one be more moral than the other? The lines are so vague, the decisions so awesome, the fear so great, the values of the past so compromised by the technology of today, that by not facing these issues consciously, the society will drift into decisions by default and a new uncritical consensus will become normative. The debate must be engaged and Christians must be part of it.

I, for one, am no longer willing to be silent on this issue. I, as a Christian, want to state publicly my present conclusions. After much internal wrestling, I can now say with conviction that I favor both active and passive euthanasia, and I also believe that assisted suicide should be legalize, but only under circumstances that would effectively preclude both self-interest and malevolence.

Perhaps a place to start would be to require by law that living wills be mandatory for all people. A second step might be to require every hospital and every community to have a bioethics committee, made up of the most respected leadership people available, to which a patient, family members, doctors or clergy persons could appeal for objective help in making these rendering decisions.

My conclusions are based on the conviction that the sacredness of my life is not ultimately found in my biological extension. It is found rather in the touch, the smile and the love of those to whom I can knowingly respond. When that ability to respond disappears permanently so, I

believe, does the meaning and the value of my biological life. Even my hope of life beyond biological death is vested in a living relationship with the God who, my faith tradition teaches me, calls me by name. I believe that the image of God is formed in me by my ability to respond to that calling Deity. If that is so, then the image of God has moved beyond my mortal body when my ability to respond consciously to that Divine Presence disappears. So nothing sacred is compromised by assisting my death in those circumstances.

The time has come for the voice of the Church to be heard publicly, consciously and deliberately in this arena. I hope that when the Church speaks on this issue, we will do so not just out of the values of the past, as great as they are, but out of the values of the future no matter how frightening they may be. I await with anticipation hearing the voice of the Christian Church in the Diocese of Newark engage this issue at our Convention.

Mr. CANADY. Dr. Kass.

**STATEMENT OF LEON R. KASS, M.D., ADDIE CLARK HARDING
PROFESSOR, THE COLLEGE AND COMMITTEE ON SOCIAL
THOUGHT, UNIVERSITY OF CHICAGO**

Dr. KASS. Thank you, Mr. Chairman. I am grateful for the opportunity to testify on this crucial moral and social matter.

Recent efforts to legalize physician-assisted suicide and to establish a constitutional "right to die" are deeply troubling events, morally dubious in themselves, extremely dangerous in their likely consequences. The legalization of physician-assisted suicide, ostensibly a measure enhancing the freedom of dying patients, is, in fact, a deadly license for physicians to prescribe death free from outside scrutiny and immune from possible prosecution. The manufacture of a so-called right to die, ostensibly a gift to those not dying fast enough, is, in fact, the State's abdication of its duty to protect innocent life and its abandonment especially of the old, the weak, and the poor.

I summarize my written testimony under four major points. First, the legalization of physician-assisted suicide will pervert the medical profession by transforming the healer of human beings into a technical dispenser of death. For over two millennia the medical ethic, mindful that the power to cure is also power to kill, has held as an inviolable rule, "Doctors must not kill." The venerable Hippocratic Oath clearly rules out physician-assisted suicide. Without this taboo, medicine ceases to be a trustworthy and ethical profession; without it, all of us will suffer—yes, more than we now suffer because some of us die too slowly.

The doctor-patient relationship will be damaged. The patient's trust in the doctor's devotion to the patient's best interest will be hard to sustain once doctors can legally prescribe death. Even conscientious physicians will have trouble caring wholeheartedly for patients once death becomes a "therapeutic option." The prohibition against killing patients recognizes that no physician devoted to the benefit of the sick can serve the patient by making him dead. The physician/suicide assistant or physician/euthanizer is a deadly self-contradiction.

Second, physician-assisted suicide once legal will not stay confined to the terminally ill and mentally competent who freely and knowingly elect it for themselves. Requests will be engineered and choices manipulated by those who control the information, and, manipulation aside, many elderly and incurable people will experience the right to choose death as their duty to do so.

Moreover the vast majority of those who are said to "merit" a "humane and dignified death" do not fall in this category and cannot request it for themselves. Persons with mental illness or Alzheimer's disease, deformed infants, or retarded or dying children would thus be denied our humane "aid in dying." But not to worry. The lawyers, encouraged by the cost containers, will sue to rectify this inequity. Why, they will argue, should the comatose and demented be denied the right to assisted suicide just because they cannot claim it for themselves? With court-appointed proxy consenters, we will quickly erase the distinction between the right to choose one's own death and the right to request someone else's.

The termination of lives someone else thinks are no longer worth living is now occurring on a large scale in Holland, where assisted suicide and euthanasia by physicians have been practiced for more than a decade under "safeguards" more stringent than those enacted in the Oregon law. According to the Dutch Government's own alarming figures, there are over a thousand cases per year of direct involuntary euthanasia; 8,100 cases of morphine overdosage intending to terminate life, 61 percent of them without the patient's consent. Although the guidelines insist that choosing death must be informed and voluntary, over 40 percent of Dutch physicians have performed involuntary euthanasia. As the Dutch have shown, the practice of assisted suicide is in principle unregulable because it is cloaked in the privacy of the doctor/patient relationship.

Third, legalizing assisted suicide would mark a drastic change in the social and political order. For the first time the State would be surrendering its monopoly on the legal use of lethal force, a monopoly it holds under the social contract, a monopoly it needs if it is to protect innocent life, its first responsibility. It should surprise no one if physicians, once they are exempted from the ban of the private use of lethal force, wind up killing without restraint. Here, by the way, is a genuine violation of the 14th amendment: deprivation of life without due process of law.

Fourth, we must care for the dying, not make them dead. By accepting mortality, yet knowing we will not kill, doctors are empowered to focus on enhancing the lives of those who are dying, with relief of pain and discomfort, moral and social support, and, when appropriate, the removal of technical interventions that are merely useless or degrading additions to the burdens of dying. Doctors must not intentionally kill or help to kill, but they may allow a patient to die.

Ceasing medical intervention, allowing nature to take its course, differs fundamentally from assisting suicide and active euthanasia. Not the physician but the underlying fatal illness becomes the true cause of death. More important morally, in ceasing treatment the physician does not intend the death of the patient, even if death follows as a result. Rather, he seeks to avoid the useless and degrading medical additions to the already sad end of a life. In contrast, in assisted suicide the physician necessarily intends primarily that the patient be made dead.

One cannot exaggerate the distinction between withholding or withdrawing treatment and directly killing, a distinction foolishly dismissed in the recent courts of appeals' decisions. Both as a matter of law and as a matter of medical ethics, the right to refuse unwanted medical intervention is properly seen not as part of a right to become dead, but rather as part of a right protecting how we choose to live, even while we are dying.

In conclusion: Once we refuse the technical fix, physicians and the rest of us can also rise to the occasion. We can learn to act humanly in the presence of finitude. Far more than adequate morphine or the removal of burdensome chemotherapy, the dying need our presence and our encouragement. Withdrawal of human contact, affection, and care is the greatest single cause of the dehumanization of dying. People who care for autonomy and dignity should try to correct this dehumanization of the end of life instead

of giving dehumanization its final triumph by welcoming the desperate goodbye to all that contained in one final plea for poison. Not the alleged humaneness of the elixir of death, but the humaneness of connected living-while-dying is what medicine and the rest of us most owe the dying. The treatment of choice is and always will be company and care.

Mr. CANADY. Thank you.

[The prepared statement of Dr. Kass follows:]

PREPARED STATEMENT OF LEON R. KASS, M.D., ADDIE CLARK HARDING PROFESSOR,
THE COLLEGE AND COMMITTEE ON SOCIAL THOUGHT, UNIVERSITY OF CHICAGO

Chairman Canady, Members of the Subcommittee:

My name is Leon R. Kass, M.D. I am Addie Clark Harding Professor in the College and the Committee on Social Thought at the University of Chicago, where I have taught for 20 years. I am also a Founding Fellow and, for 26 years, a Board member of The Hastings Center, and past chairman of its task force on death and dying. For almost thirty years I have studied and written about biomedical ethics, with special attention to ethical issues in the care of the dying, including physician-assisted suicide, euthanasia, and the so-called "right-to-die." A bibliography of my most relevant articles, which discuss more fully the issues I raise today, appears at the end of this testimony. I am submitting copies of several of these articles to the subcommittee and would ask that they be included in the Record as supplements to my testimony. The arguments I offer are based on fundamental principles of medical ethics, supported by studies in moral and political philosophy, as well as insights gained by considering current medical and social practices here and abroad; to the best of my knowledge, my arguments do not depend on any parochial or sectarian religious or theological teachings.

* * *

To no one's surprise, death has crept onto our nation's legislative and judicial agendas. In 1994, voters in Oregon narrowly approved a "Death with Dignity" ballot initiative, making Oregon the first jurisdiction anywhere in the world to legalize physician-assisted suicide; other states are considering similar legislation. This year, decisions by two Federal Courts of Appeal (Ninth and Second Circuits) struck down laws prohibiting assisted suicide, using Fourteenth Amendment jurisprudence

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to establish a constitutional "right to die," at least for so-called terminally ill and competent patients. These are extremely troubling developments, morally and philosophically dubious in themselves, extremely dangerous in their consequences. The evils they embody are difficult to recognize and to combat because they are not the evils of malicious intent or violent manner; they are rather "humanitarian evils" —well-meaning, compassionate, allegedly "liberating," and seemingly rational, indeed, over-confidently rationalistic. The legalization of physician-assisted suicide, ostensibly a measure enhancing the freedom of dying patients, is in fact a deadly license for physicians to prescribe death, free from outside scrutiny and immune from possible prosecution. The manufacture of a "right to die," ostensibly a gift to those not dying fast enough, is, in fact, the state's abdication of its duty to protect innocent life and its abandonment especially of the old, the weak, the despondent, the depressed, the poor, and the uneducated, many of whom will be subtly or not so subtly prodded or coerced into doing their "duty" to exercise their newly won "right" to die. All of these dangers are packaged in the name of a "humane and dignified death."

Who doesn't want a dignified death? Dying, never easy, is for many now harder than ever, thanks to the successes, and excesses, of modern medicine. Of the 2.2 million annual deaths in the United States, 80 percent occur in health-care facilities; in roughly 1.5 million of these cases, death is preceded by some explicit decision to stop or not start medical treatment. Often worse than dying is the fear: of pain, degradation, and loss of self-command; of becoming a burden to our families; or of being abandoned by those we love. Relief from pain and suffering, respect for our humanity, and, above all, kind words, gentle deeds, and the loyal presence of those who matter to us—all these we

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need and deserve while dying. Having a say in our terminal care, being able to avoid unwelcome machinery and to withdraw from treatment or from hospital, gaining access to a hospice's devoted care—these, too, are crucial to the possibility of dying well.

But no new changes in the law are required to obtain these rights and benefits. We already have the right to refuse all unwanted medical interventions, including life-prolonging treatments such as the respirator or the feeding tube. In many states, it is already illegal to prolong the act of dying against the patient's will. Living wills and advance directives have legal force in nearly every state. Thanks to medical advances and the hospice movement, effective pain control that does not blunt consciousness and comfortable dying are now possible for almost everyone. Legal, effective, humane and dignified aid-in-dying is already available, at least in principle.

But before we have had the opportunity to extend these recently won rights and benefits to everyone, and to learn how to care properly for dying patients, the Oregon law and the Court of Appeals decisions rush in to add physician-assisted suicide. This crossing of the line between allowing to die and intentionally killing is worse than unnecessary; it is very dangerous. Under this new legal dispensation, dignity-in-dying comes to mean merely a technical final solution. Relief of suffering becomes the elimination of the sufferer. Most dangerously, the new laws will transform the doctor, healer of human beings, into a technical dispenser of death.

Do we really want our doctors to be licensed agents of death? Should they be permitted or encouraged to prescribe (and, later, to inject) poison? Shall the mantle of privacy that protects the doctor-patient relationship, in the service of life, now also cloak decisions for

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death? Do you want your doctor deciding, on the basis of his own private views, when you still deserve to live and when you now deserve to die, when you should be offered death as a "therapeutic option"? And what about the doctor you would never go to: do you want him also licensed to kill? In short, shall the healing profession become also the death-dealing profession?

Common sense has always answered no. For over two millennia, the reigning medical ethic, mindful that power to cure is also power to kill, has held as an inviolable rule, "Doctors must not kill." The venerable Hippocratic Oath clearly rules out physician-assisted suicide: "I will give no deadly drug if asked for it, neither will I make a suggestion to this effect." Proponents of physician-assisted suicide and euthanasia try to convince us that this taboo is but an irrational vestige of religious prejudice, alien to a true ethic of medicine. They insist that it prevents the most rational and humane approach to ending suffering. Nothing could be further from the truth.

The Oath's authors—pagans, not papists—were wise students of human nature and their own frailties. They understood the need to restrain their awesome power over life and death; they protected not only against the weaknesses and mischief of others but also against their own weaknesses and the lurking temptation to do away with burdensome patients. The taboo against doctors killing patients even on request is thus the very embodiment of reason and wisdom. Without it, medicine will cease to be an ethical and trustworthy profession; without it, all of us will suffer—yes, more than we now suffer because some of us do not die soon enough.

Consider first the damaging consequences for the doctor-patient relationship. The patient's trust in the doctor's whole-hearted devotion

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to his best interests will be hard to sustain once doctors are licensed to kill. Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. Never mind that, for now, death can be legally prescribed only on request. How soundly will you sleep?

How will even the most conscientious physicians be able to care whole-heartedly for patients once death becomes a "therapeutic option"? Shall it be penicillin and a respirator one more time or, perhaps this time, just an overdose of morphine? Physicians get tired of treating patients whose illnesses resist their best efforts, who are on their way down—"gorks," "gomers," and "vegetables" are only some of the names medical staff use for patients with intractable illnesses. Hospital administrators and HMO budget officers are already pressuring them to cut the costs of treatment, especially in these patients. Won't doctors be tempted to select or encourage death as the best "treatment," say, for the little old lady dumped again on an overloaded emergency room by the nearby nursing home?

It is naive and foolish to take comfort from the fact that the currently proposed change in the law seeks to provide physician aid-in-dying only to those who request it. We all know from long experience how difficult it is to discover what we truly want when we are suffering; a demand for assisted suicide or euthanasia is often, in fact, an angry or anxious plea for help, born of fear of rejection or abandonment, or made in ignorance of available pain-alleviating and other comforting alternatives. Countless people with serious illnesses, and most people requesting suicide-assistance, also suffer from treatable clinical depression, alas, usually undiagnosed which leads them to take an

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excessively gloomy view of their situation. Shall physicians who can't recognize depression or who won't provide proper pain relief and human understanding be given the power to prescribe instead for death?

It is all too easy for physicians, because they control the information, to engineer requests and to manipulate the choices of the vulnerable. Presented with a horrible prognosis and the offer of a "gentle quick release," what will the depressed or frightened patient likely choose, especially in the face of a spiraling hospital bill or resentful children? Yale Kamisar asks the right questions:

Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel that they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act? Will not some feel an obligation to have themselves 'eliminated' in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved? (Emphasis added)

Anyone who knows anything at all about the elderly and the incurable knows that many, many of them will, in everyday life, experience their right to choose physician-assisted death as a duty to do so.

Neither should we be reassured that assisted-suicide will be available, for the time being, only for the terminally-ill. Terminal illness is notoriously difficult to define precisely and almost as difficult to

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predict accurately. Does the frequently used estimate of less than six months to live mean six months with or without other forms of treatment? Besides, medical predictions are easily falsified: almost none of Dr. Kevorkian's "patients" were terminally ill. Would an obligatory second opinion give adequate protection against error or falsification of prognosis, given that doctors are usually loathe to contradict one another, and are especially prone to collusion where keeping the patient alive will be costly to their institution or business?

Even without such abuses, physician-assisted suicide cannot be confined to those terminally-ill who will themselves administer the deadly drug the doctor has prescribed. What if the patient's disease prevents him from putting the pills into his mouth or from swallowing them? What if he vomits them up or if, for some other reason, the usually "lethal dose" does not produce death in his case? Will the physician stand idly by? Of course not: He is now committed to the patient's death, and he will surely lend a hand.

Neither will he be bound to regard terminal illness, however defined, as a *sine qua non* for prescribing for death. For if suicide (and its assistance) is justified by a right to choose the time and manner of one's death (as it is in the Ninth Circuit's decision), then the whole matter is too personal, intimate, and subjective to be governed by any objective or demonstrable criteria, such as certifiable terminal illness or truly intractable pain. For who is to say what makes suffering or life "unbearable" or death "electable" for another person? The autonomy argument favored by the courts sooner or later kicks out all criteria for evaluating the patient's choice, save that it be "uncoerced."

But, of course, no one, at least today, wants to leave it at that. Instead, reasons are given to justify choosing death: too much pain, loss

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of dignity, lack of self-command, poor quality of life. These are supposed to add up to a plausible verdict: life is no longer worth living. Such "useless" or "degrading" or "dehumanized" lives now plead for active, "merciful" termination—*choice or no choice*.

It is therefore naive to think that we can draw and hold a line between physician-assisted suicide or physician-aid-in-dying (a euphemism for voluntary active euthanasia, practiced by doctors on willing patients) and involuntary euthanasia (where physicians perform mercy-killing without the patient's request). The line cannot be sustained even in theory; for once suicide and assisting suicide are okay, for reasons of "mercy," then delivering the dehumanized is okay, whether chosen or not. Physician-assisted suicide, once legalized, will not remain confined to those who freely and knowingly elect it—and the most energetic backers of euthanasia do not really want it thus restricted. They see the slippery slope and eagerly embrace the principle that will justify the entire downward slide. Why? Because the vast majority of candidates who merit mercy-killing cannot request it for themselves. Persons in a persistent vegetative state; those suffering from severe depression, senility, mental illness, or Alzheimer's disease; infants who are deformed; and retarded or dying children—all are incapable of requesting death, and they would thus be denied the new humane aid-in-dying.

But not to worry. Lawyers and doctors, urged on by the cost-containers, will soon rectify this inequity. Why, they will argue in court on grounds of equal protection of the laws, should the comatose or the demented be denied the right to assistance-in-dying just because they cannot claim it for themselves? With court-appointed proxy consentors, we will quickly erase the distinction between the right to choose one's

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own death and the right to request someone else's—as we have already done in the termination of treatment cases.

(It appears that no sensible distinctions are safe, under equal protection clause jurisprudence, if the recent opinion of the Second Circuit is any precedent: it holds that the current law permitting refusal of treatment discriminates unfairly in favor of those who can elect to pull the plug on life-supporting machinery and against those who want to die but who [because of the vagaries of their condition] have no plug to pull. This strikes one as a tort claim made against fate or nature! A similar claim could equally well be made on behalf of those who wish to die but who are not terminally ill, or on behalf of those whose condition merits merciful aid-in-dying but who, ill-fated ones, cannot ask for it themselves.)

Clever doctors and relatives will not need to wait for such changes in the law. Who will be around to notice when the elderly, poor, crippled, weak, powerless, retarded, depressed, uneducated, demented, or gullible are mercifully released from the lives their doctors, nurses, and next of kin deem no longer worth living?

This is no mere scare-mongering. Recent reports on the practice of euthanasia in Holland provide ample proof. Although assisted suicide and voluntary euthanasia by physicians are technically still against the law there, their practice has been tolerated, even encouraged, for nearly 20 years, under guidelines established by the medical profession. (These guidelines offer “safeguards” more stringent than the Oregon law.) Although the guidelines insist that choosing death must be informed and voluntary, a 1989 survey of 300 physicians (conducted by the supporters of euthanasia) disclosed that over 40 percent had performed involuntary euthanasia and over 10 percent had done so five times or

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more. The Report of the Dutch Government's Committee to Investigate the Practice of Euthanasia (September 1991) provides even more alarming data: in addition to 2,300 cases of voluntary euthanasia and 400 cases of physician-assisted suicide per year, there were over 1,000 cases of active involuntary euthanasia performed without the patient's knowledge or consent, including over 100 cases in which the patients were mentally competent. (Comparable rates of involuntary euthanasia for the United States would be roughly 20,000 cases per year.) Eight thousand one hundred morphine overdoses were documented with the intent to terminate life, 61 percent without patient knowledge or consent. In nearly half the cases of termination without consent, the families also were not consulted or informed. Despite a notification requirement, less than 10% of physician-assisted deaths are reported as such.

And why are Dutch physicians performing involuntary euthanasia? "Low quality of life," "the family couldn't take it any more," and "little hope of improvement" were reasons that physicians gave for killing patients without request. Is there any reason to believe that the average Dutch physician is less committed than his American counterpart to the equal dignity of every life under his care?

Given the Dutch experience, it is surprising that almost no commentator has noticed that permitting physicians to assist in suicide or practice euthanasia represents a drastic change in the social and political order. For the state has thereby surrendered its monopoly on the legal use of lethal force, a monopoly it holds under the social contract and a monopoly it needs if it is to protect innocent life, its first responsibility. True, many people own guns and are legally entitled to use them in self-defense; but not until physicians get a license to

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prescribe death will anyone be allowed to stand outside the community in this crucial regard. It should surprise no one if those who are exempted from the ban on the private use of lethal force wind up killing without restraint.

Simple reflection reveals another reason why no law can provide the desired protection against the slide into mercy-killing and involuntary euthanasia. The entire practice must take place within the sanctuary of the doctor-patient relationship. Neither patient nor physician wants outsiders looking in. Herein lies an unresolvable dilemma: How can we insist that euthanasia is a matter of personal right and private choice, best handled privately between patient and doctor, and yet expect there to be appropriate oversight, public accountability and control? We shall be forced to rely solely on the fragile virtue of the medical profession to protect the exposed and vulnerable lives of the infirm, the elderly, and the powerless—people incapable of real autonomy, who will be deemed by others to have lives no longer worth sustaining at great expense. Once the taboo against killing falls, how many physicians will be able to restrain themselves from dispatching these “useless lives”?

Even the most humane and conscientious physician psychologically needs protection against himself and his weaknesses if he is to care fully for those who entrust themselves to him. A physician-friend who worked many years in a hospice caring for dying patients explained it to me most convincingly: “Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying.” The psychological burden of the license to kill, not to speak of the brutalization of the physician-killers,

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would be an intolerably high price to pay for physician-assisted suicide and euthanasia.

The point, however, is not merely psychological: it is also moral and essential. My friend's horror at the thought that he might be tempted to kill his patients, were he not enjoined from doing so, embodies a deep understanding of the medical ethic and its intrinsic limits.

The beginning of ethics regarding the use of power generally lies in nay-saying. Setting limits on the use of power is based on discerning the excesses to which the unrestrained power is prone. Applied to most professions, this principle establishes strict outer boundaries—indeed, inviolable taboos—against unique “occupational hazards.” Within these limits, no fixed rules of conduct apply; instead, prudence—the wise judgment of the man-on-the-spot—finds and adopts the best course of action in the light of the circumstances. But the outer limits themselves are fixed, firm, and non-negotiable.

What are the limits for medicine? At least three are set forth in the venerable Hippocratic Oath: no breach of confidentiality; no sexual relations with patients; no dispensing of deadly drugs. Each of these unqualified, self-imposed restrictions can be readily understood in terms of the temptations to which the physician is most vulnerable; each deals with an area of vulnerability and exposure that the practice of medicine requires of patients. Patients necessarily divulge and reveal private and intimate details of their personal lives; patients necessarily expose their naked bodies to the physician's gaze and investigating hands; patients necessarily expose and entrust the care of their very lives to the physician's skill, technique, and judgment. Mindful of the meaning of such non-mutual exposure, the physician voluntarily sets limits on his

own conduct, pledging not to take advantage of, or to violate, the patient's intimacies, sexuality, or life itself.

The prohibition against killing patients, the first negative promise of self-restraint sworn to in the Hippocratic Oath, stands as medicine's first and most-abiding taboo: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. . . . In purity and holiness I will guard my life and my art." In forswearing the giving of poison, the physician recognizes and restrains a god-like power he wields over patients, mindful that his drugs can both cure and kill. But in forswearing the giving of poison, *when asked for it*, the Hippocratic physician rejects the view that the patient's choice for death can make killing him—or assisting his suicide—right. Human life in living bodies commands respect and reverence by its very nature.

The deepest ethical principle restraining the physician's power is not and cannot be the autonomy or freedom of the patient. Neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself and, therefore, also what the Oath calls the purity and holiness of the life and art to which he has sworn devotion. A person can choose to be a physician, but he cannot simply choose what physicianship means.

The central meaning of physicianship derives not from medicine's powers but from its goal, not from its means but from its end: to heal the sick. The physician as physician serves only the sick. He does not serve the relatives or the hospital or the national debt inflated due to Medicare costs. Thus he will never sacrifice the well-being of the sick to the convenience, or pocketbook, or feelings of the patient's relatives or society. Moreover, the physician serves the sick not because they have rights or wants or claims but because they are sick. The healer works

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with and for those who need to be healed, in order to help make them whole. Despite enormous changes in medical technology and institutional practice, nosology, and therapeutics, the center of medicine has not changed. It is as true today as it was in the days of Hippocrates that the ill desire to be whole; that wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire, move, and maintain itself. The relationship between the healer and the ill is still constituted, essentially even if only tacitly, around the desire to promote the wholeness of the one who is ailing.

Can wholeness and healing ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead? There is, of course, a logical difficulty: how can any good exist for a being that is not? But the error is more than logical: to intend and to act for someone's good requires his continued existence to receive the benefit.

To be sure, certain attempts to benefit may in fact turn out, unintentionally, to be lethal. Giving morphine adequate to control pain might induce respiratory depression leading to death. But the action to relieve the pain presupposes that the patient remain alive to be relieved. Obvious as it may seem, the starting point in discussing all medical benefits must be that there can be no benefit without a beneficiary.

Someone will surely bring forth the hard cases: patients so ill-served by their bodies that they can no longer bear to live, bodies so riddled with cancer and so racked with pain that their "owners" insist on being released from them. Why can't the person protest his embodiment and request death for "personal" reasons?

However sympathetically we listen to such requests, we must see them as incoherent, because any such person-body dualism cannot be

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sustained. "Personhood" is manifest on earth only in living bodies; our highest mental functions are held up by and are inseparable from lowly metabolism, respiration, circulation, excretion. There may be blood without consciousness, but there is never consciousness without blood. No physician, devoted to the benefit of the sick, can serve the person as person by denying and thwarting his personal embodiment.

To say it plainly, to bring nothingness is incompatible with serving wholeness: one cannot heal or comfort by making nil. The healer cannot annihilate if he is truly to heal. The physician-as-suicide-assistant or physician-euthanizer is a deadly self-contradiction.

But we must acknowledge that the central goal of medicine—health—is, in each case, a perishable good. Inevitably, patients become irreversibly sick, patients degenerate, patients die. Healing the sick is a project that must at some point fail. And here is where the trouble begins: How does one deal with "medical failure"? What does one seek when restoration of wholeness is by and large out of the question?

Contrary to the propaganda of the euthanasia movement, there is much that can be done. Indeed, by recognizing finitude yet knowing that we will not kill, we are empowered to focus on easing and enhancing the lives of those who are dying. First of all, medicine can follow the lead of the hospice movement and—correcting for decades of shameful mismanagement—concentrate on providing truly adequate relief from pain and discomfort. Second, physicians, patients, and families can continue to learn how to withhold or withdraw technical interventions that are merely burdensome or degrading additions to the unhappy end of life—including, frequently, hospitalization itself. Ceasing treating and allowing death to occur when and if it will are quite compatible with the

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respect life itself commands for itself. Doctors must not intentionally kill or help to kill, but they may allow a patient to die.

Ceasing medical intervention, allowing nature to take its course, differs fundamentally from assisted suicide, active euthanasia, and mercy killing. For one thing, death does not necessarily follow the discontinuance of treatment; Karen Ann Quinlan lived more than ten years after the court allowed the "life-sustaining" respirator to be removed. Not the physician, but the underlying fatal illness becomes the true cause of death. (It is both naive and thoughtless to believe that we can exercise a right to "control the time and manner of one's death," since these aspects of death, like death itself, display the limits of human control; only by killing oneself or by arranging to be killed on schedule can such control in fact be exercised. Such a result exposes the shallowness of our exaggerated belief in mastery over nature and fortune, a belief that informs the Ninth Circuit's opinion and, indeed, our entire technological approach to death.)

More important morally, in ceasing treatment the physician does not intend the death of the patient, even if death follows as a result of his omission. His intention is to avoid useless and degrading medical additions to the already sad end of a life. In contrast, in assisted suicide and all other forms of direct killing the physician must, necessarily and indubitably, intend primarily that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death. This remains true even if he is merely an assistant in suicide. A physician who provides the pills or lets the patient plunge the syringe after he leaves the room is morally no different from one who does the deed himself. "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."

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One cannot exaggerate the importance of this distinction between withholding or withdrawing treatment and directly killing, especially in light of the casual and dismissive way it has been treated in the two recent Court of Appeals' decisions. Both as a matter of law and as a matter of medical ethics, the right to refuse unwanted medical intervention is properly seen not as part of a right to become dead but rather (like the rest of the doctrine of informed consent) as part of a right protecting how we choose to live, even while we are dying. Doctors and patients choose whether to begin treatment on the basis of a prudent judgment weighing benefits and burdens. In the event of doubt, we almost invariably err on the side of life and hope for recovery. But after a proper trial, when recovery seems beyond reasonable possibility, when the patient's condition deteriorates, we are medically and morally free to abandon the therapeutic trial, even if death results. It would be improper to say that the intent of this discontinuance—whether by a physical act of omission or commission—is that the patient become dead. Rather, we intend to cease doing useless and futile or degrading things to the patient when he no longer stands to benefit from them.

The following analogy should make the point vivid: As the flood waters rise, I put my finger in the dike to stop a leak and to prevent my house from being flooded. But, as the still rising water threatens to pour over the top or the dike prepares to crack in many other places, I see the futility of keeping my finger in the dike. But in removing it, I cannot be said either to intend or even to cause the flooding of my house. In contrast, I would both intend and cause the flooding were I deliberately to introduce large holes into the dike, unwilling to wait for the unknown outcome of the rising water.

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It is therefore false to say (as the Ninth Circuit says) that physicians who today run increased risks of death in order to provide adequate pain medication are knowingly and intentionally killing their patients. No doubt, some physicians, already far down the slippery slope to involuntary euthanasia, may be abusing this so-called principle of "double-effect," and may secretly be intending death when appearing to be administering pain relief. But such abuse in no way invalidates the moral centrality of the distinction, and in no way justifies blurring the only line that can morally and clearly be drawn in these vexing matters.

Once we refuse the technical fix, physicians and the rest of us can also rise to the occasion: we can learn to act humanly in the presence of finitude. Far more than adequate morphine and the removal of burdensome chemotherapy, the dying need our presence and our encouragement. Because a dignified human life is not just a lonely project against an inevitable death, but a life whose meaning is entwined in human relationships, it is clear that a death with dignity—like a life with dignity—requires dignified human intercourse with all those around us. Our own exercise of dignified humanity will depend crucially on continuing to receive respectful and attentive treatment from others. The manner in which we are addressed, what is said to us or in our presence, how our bodies are tended or our feelings regarded—in all these ways, our dignity in dying can be nourished and sustained. Dying people are all too easily reduced ahead of time to "thinghood" by those who cannot bear to deal with the suffering or disability of those they love. Withdrawal of contact, affection, and care is the greatest single cause of the dehumanization of dying. Medicine most owes the dying not the alleged humaneness of an elixir of death, but the humanness of

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connected living-while-dying. The treatment of choice is company and care.

The euthanasia movement would have us believe that the physician's refusal to assist in suicide or perform euthanasia constitutes an affront to human dignity. Yet one of their favorite arguments seems to me rather to prove the reverse. Why, it is argued, do we put animals out of their misery but insist on compelling fellow human beings to suffer to the bitter end? Why, if it is not a contradiction for the veterinarian, does the medical ethic absolutely rule out mercy killing? Is this not simply inhumane?

Perhaps inhumane, but not thereby inhuman. On the contrary, it is precisely because animals are not human that we must treat them merely humanely. But any conscious human being who asks for death displays by that very request a human presence that precludes anyone's treating him as a dumb animal. Indeed, despite illness, suffering, or declining powers, nearly all the people who are said to be fit candidates for assisted suicide or euthanasia still manifest clear signs of humanity, even when it comes down to just a smile of recognition or the touch of a hand. (The permanently unconscious ones do not suffer; contrary to the propaganda, they are therefore not really candidates for mercy killing. We may not be obliged to prolong their lives, but even here we must not kill, out of respect for the full human lives they once lived, and also to avoid our needless brutalization.) Humanity is owed humanity, not humaneness. Humanity is owed the bolstering of the human, even or especially in its dying moments, in resistance to the temptation to ignore its presence in the sight of suffering.

What humanity needs most in the face of evils is courage, the ability to stand against fear and pain and thoughts of nothingness. The

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deaths we most admire are those of people who, knowing that they are dying, face the fact frontally and act accordingly. They set their affairs in order, they arrange what could be final meetings with their loved ones, and yet with strength and hope, they continue to live and work and love as much as they can for as long as they can. Because such conclusions of life require courage, they call for our encouragement and for the many small speeches and deeds that shore up the human spirit against despair and defeat.

Many doctors are in fact rather poor at this sort of encouragement. They tend to regard every dying or incurable patient as a failure, as if an earlier diagnosis or a more vigorous intervention might have avoided what is, in truth, an inevitable collapse. The enormous successes of medicine these past 50 years have made both doctors and laymen less prepared than ever to accept the fact of finitude. Physicians today are not likely to be agents of encouragement once their technique begins to fail.

It is, of course, partly for these reasons that doctors will be pressed to kill—and many of them will, alas, be willing. Having adopted a largely technical approach to healing, having medicalized so much of the end of life, doctors are being asked—often with thinly veiled anger—to provide a final technical solution for human finitude and for their own technical failure: If you cannot cure me, Doctor, kill me. The last gasp of autonomy or cry for dignity is asserted against a medicalization and institutionalization of the end of life that robs the old and the incurable of most of their autonomy and dignity: intubated and electrified, with bizarre mechanical companions, once proud and independent people find themselves cast in the roles of passive, obedient, highly disciplined children. People who care for autonomy and dignity should try to

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reverse this dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate goodbye-to-a'll-that contained in one final plea for poison.

The present crisis that leads some to press for assisted suicide and active euthanasia is really an opportunity to learn the limits of the medicalization of life and death and to recover an appreciation of living with and against mortality. It is an opportunity for all of us to recover an understanding that there remains a residual human wholeness—however precarious—that can be cared for even in the face of incurable and terminal illness. If we cave in and legalize assisted suicide and euthanasia, if doctors are compelled to become technical dispensers of death, they will not only be abandoning their posts, their patients, and their duty to care; they will also set the worst sort of example for the community at large. They will teach technicism and so-called humaneness where encouragement and humanity are both required and sorely lacking. On the other hand, should we hold fast, should we reject the shallow notion that “dignity” can be delivered by a hypodermic needle filled with lethal drugs, should we learn that finitude is no disgrace and that human wholeness can be cared for to the very end, the venerable art of medicine may continue to serve not only the good of its patients, but also, by example, the failing moral health of modern times.

Death With Dignity & the Sanctity of Life

Leon R. Kass

*Dedicated to the memory of my mother,
Chana Kass (1903-1989), my first and best
teacher regarding human dignity.*

"CALL no man happy until he is dead." With these deliberately paradoxical words, the ancient Athenian sage Solon reminds the self-satisfied Croesus of the perils of fortune and the need to see the end of a life before pronouncing on its happiness. Even the richest man on earth has little control over his fate. The unpredictability of human life is an old story; many a once-flourishing life has ended in years of debility, dependence, and disgrace. But today, it seems, the problems of the ends of lives are more acute, a consequence, ironically, of successful—or partly successful—human efforts to do battle with fortune and, in particular, to roll back medically the causes of death. While many look forward to further triumphs in the war against mortality, others here and now want to exercise greater control over the end of life, by electing death to avoid the burdens of lingering on. The failures resulting from the fight against fate are to be resolved by taking fate still further into our own hands.

This is no joking matter. Nor are the questions it raises academic. The emerge, insistently and urgently, from poignant human situations, occurring daily in hospitals and nursing homes, as patients and families and physicians are compelled to decide matters of life and death, often in the face only of unattractive, even horrible, alternatives. Shall I allow the doctors to put a feeding tube into my eighty-five-year-old mother, who is unable to swallow as a result of a stroke? Now that it is inserted and she is not recovering, may I have it removed? When would it be right to remove a respirator, forgo renal dialysis, bypass life-saving surgery, or omit giving antibiotics for pneumonia? When in the course of my own progressive dementia will it be right for my children

to put me into a home or for me to ask my doctor or my wife or my daughter for a lethal injection? When, if ever, should I as a physician or husband or son accede to—or be forgiven for acceding to—such a request?

These dilemmas can be multiplied indefinitely, and their human significance is hard to capture in words. For one thing, posing them as well-defined problems to be solved abstracts from the full human picture, and ignores such matters as the relations between the generations, the meaning of old age, attitudes toward mortality, religious faith, economic resources, and the like. Also, speech does not begin to convey the anguish and heartache felt by those who concretely confront such terrible decisions, nor can it do much to aid and comfort them. No amount of philosophizing is going to substitute for discernment, compassion, courage, sobriety, tact, thoughtfulness, or prudence, all needed on the spot.

Yet the attitudes, sentiments, and judgments of human agents on the spot are influenced, often unwittingly, by speech and opinion, and by the terms in which we formulate our concerns. Some speech may illuminate, other speech may distort; some terms may be more or less appropriate to the matter at hand. About death and dying, once subjects treated with decorous or superstitious silence, there is today an abundance of talk—not to say indecorous chatter. Moreover, this talk frequently proceeds under the aegis of certain increasingly accepted terminologies, which are, in my view, both questionable in themselves and dangerous in their influence. As a result, we are producing a recipe for disaster: urgent difficulties, great human anguish, and high emotions, stirred up with inadequate thinking. We have no choice but to reflect on our speech and our terminology.

LET me illustrate the power—and the possible mischief—of one notion currently in vogue: the notion of rights. It is now fashionable, in many aspects of public life, to demand what one wants or needs as a matter of rights. How to do the right thing gets translated into a right to get or do your own thing. Thus, roughly two decades ago, faced with the unwelcome fact of excessive medical efforts to forestall death, people asserted and won a right to refuse life-prolonging treatment found to be useless or burdensome. This was, in fact, a reaffirmation of

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the right to life, liberty, and the pursuit of happiness, even in the face of imminent death. It enabled dying patients to live as they wished, free of unwelcome intrusions, and to let death come when it would. Today, the demand has been raised: we find people asserting a "right to die," grounded not in objective conditions regarding prognosis or the uselessness of treatment, but in the supremacy of choice itself. In the name of choice people claim the right to choose to cease to be choosing beings. From such a right to refuse not only treatment but life itself—from a right to become dead—it is then a small step to the right to be *made* dead: from my right to die will follow your duty to assist me in dying, i.e., to become the agent of my death, if I am not able, or do not wish, to kill myself. And, thanks to our egalitarian tendencies, it will continue to be an easy step to extend all these rights even to those who are incapable of claiming or exercising them for themselves, with proxies empowered to exercise a right to demand death for the comatose.¹ No one bothers very much about where these putative rights come from or what makes them right, and simple reflection will show that many of them are incoherent.

Comparable mischief can, of course, be done beginning with the notion of duty. From the acknowledged human duty not to shed innocent blood follows the public duty to protect life against those who would threaten it. This gets extended to a duty to preserve life in the face of disease or other non-human dangers to life. This gets extended to a duty to prolong life whenever possible, regardless of the condition of that life or the wishes of its bearer. This gets extended to an unconditional duty never to let death happen, if it is in one's power to do so. This position, sometimes alleged—I think mistakenly—to be entailed by belief in the "sanctity of life," could even make obligatory a search for the conquest of death altogether, through research on aging. Do we have such duties? On what do they rest? And can such a duty to prevent death—or a right to life—be squared with a right to be made dead? Is not this intransigent language of rights and duties unsuitable for finding the best course of action, in these terribly ambiguous and weighty matters? We must try to become more thoughtful about the terms we use and the questions we pose.

Toward this end I wish to explore here the relation between two other powerful notions, both prominent in the discussions regarding the end of life: death with dignity, and the sanctity of life. Both convey elevated, indeed lofty, ideas: what, after all, could be higher than human dignity, unless it were something sacred? As a result, each phrase often functions as a slogan or a rallying cry, though seldom with any regard for its meaning or ground. In the current debates about euthanasia, we are often told that these notions pull in opposite directions. Upholding death with dig-

nity might mean taking actions that would seem to deny the sanctity of life. Conversely, unwaveringly upholding the sanctity of life might mean denying to some a dignified death. This implied opposition is, for many of us, very disquieting. The dilemmas themselves are bad enough. Much worse is it to contemplate that human dignity and sanctity might be opposed, and that we may be forced to choose between them.²

THE confrontation between upholders of death with dignity and upholders of the sanctity of life is in fact nothing new. Two decades ago, the contest was over termination of treatment and letting die. Today and tomorrow, the issue is and will be assisted suicide, mercy killing, so-called active euthanasia. On the extremes stand the same opponents, many of whom—I think mistakenly—think the issues are the same. Many who now oppose mercy killing or voluntary euthanasia then opposed termination of treatment, thinking it equivalent to killing. Those who today back mercy killing in fact agree: if it is permissible to choose death by letting die, they argue, why not also by active steps to hasten, humanely, the desired death? Failing to distinguish between letting die and making dead (by failing to distinguish between intentions and deeds, causes and results, goals and outcomes), both sides polarize the debate, opposing not only one another but also those in the uncomfortable middle. For them, it is *either* sanctity of life or death with dignity: one must choose.

I do not accept this polarization. Indeed, in the rest of this essay I mean to suggest the following. First, human dignity and the sanctity of life are not only compatible, but, if rightly understood, go hand in hand. Second, death with dignity, rightly understood, has largely to do with exercising the humanity that life makes possible, often to the very end, and very little to do with medical procedures or the causes of death. Third, the sanctity-and-dignity of life is entirely compatible with letting die but not with deliberately killing. Finally, the practice of euthanasia will not promote human dignity, and our rush to embrace it will in fact only accelerate the various tendencies

¹ Precisely such a (constitutionally protected) right to become dead, claimed by proxies on behalf of a permanently comatose other, is being asserted in the *Cruzan* case, now under review by the United States Supreme Court.

² Some people, in contrast, are delighted with this polarized framing of the question. For they see it as the conflict between a vigorous humanism and an anachronistic otherworldliness foisted upon the West by the Judeo-Christian tradition. For those who deny the sacred, it is desirable to represent the arguments against suicide or mercy killing (or abortion) as purely religious in character—there being in truth, on their view, nothing higher than human dignity. The chief proponent of the recent "Humane and Dignified Death Act" in California is reported to have said that he was seeking to "overturn the sanctity-of-life principle" in American law.

in our society that undermine not only dignified conduct but even decent human relations.

The Sanctity of Life (and Human Dignity)

WHAT exactly is meant by the sanctity of life? This turns out to be difficult to say. In the strictest sense, sanctity of life would mean that life is *in itself* something holy or sacred, transcendent, set apart—like God Himself. Or, again, focusing on our responses to the sacred, it would mean that life is something before which we stand (or should stand) with reverence, awe, and grave respect—because it is beyond us and unfathomable. In more modest but also more practical terms, to regard life as sacred means that it should not be violated, opposed, or destroyed, and, positively, that it should be protected, defended, and preserved. Despite their differences, these various formulations agree in this: that “sacredness,” whatever it is, inheres in life itself, and that life, *by its very being*, calls forth an appropriate human response, whether of veneration or restraint. To say that sacredness is something that can be conferred or ascribed—or removed—by solely human agreement or decision is to miss the point entirely.

I have made a modest and so far unsuccessful effort to trace the origin of the sanctity-of-life doctrine in our own Judeo-Christian traditions. To the best of my knowledge, the phrase “sanctity of life” does not occur either in the Hebrew Bible or in the New Testament. Life as such is not said to be holy (*qādash*), as is, for example, the Sabbath. The Jewish people are said to be a holy people, and they are enjoined to be holy as God is holy. True, traditional Judaism places great emphasis on preserving human life—even the holy Sabbath may be violated to save a life, implying to some that a human life is more to be revered than the Sabbath—yet the duty to preserve one’s life is not unconditional: to cite only one example, a Jew should accept martyrdom rather than commit idolatry, adultery, or murder.

As murder is the most direct assault on human life and the most explicit denial of its sanctity, perhaps we gain some access to the meaning of the sanctity of life by thinking about why murder is proscribed. If we could uncover the ground of restraint against murder, perhaps we could learn something of the nature of the sanctity of life, and, perhaps, too, of its relation to human dignity. As a result, we might be in a better position to consider the propriety of letting die, of euthanasia, and of other activities advocated by the adherents of “death with dignity.”

Why is killing another human being wrong? Can the prospective victim’s request to be killed nullify the wrongness of such killing, or, what is more, make such killing right? Alternatively, are there specifiable states or conditions of a human being’s life that would justify—or ex-

cuse—someone else’s directly and intentionally making him dead, even *without* request? The first question asks about murder, the second and third ask whether assisting suicide and mercy killing (so-called active euthanasia) can and should be morally distinguished from murder. The answers regarding assisting suicide and euthanasia will depend on the answer regarding murder, that is, on the *reasons* it is wrong.³

WHY is murder wrong? The laws against murder are, of course, socially useful. Though murders still occur, despite the proscriptive law and the threat of punishment, civil society is possible only because people generally accept and abide by the reasonableness of this rule. In exchange for society’s protection of one’s own life against those who might otherwise take it away, each member of society sacrifices, in principle, his (natural) right to the lives of all others. Civil society requires peace, and civil peace depends absolutely on the widespread adherence to the maxim, “Thou shalt not murder.” This usefulness of the taboo against murder is sometimes offered as the basis of its goodness: killing is bad because it makes life unsafe and society impossible.

But this alone cannot account for the taboo against murder. In fact, the goodness of civil society is itself predicated upon the goodness of human life, which society is instituted to defend and foster. Civil society exists to defend the goods implicit in the taboo against murder, at least as much as the taboo against murder is useful in preserving civil society.

However valuable any life may be to society, each life is primarily and preeminently valued by the person whose life it is. Individuals strive to stay alive, both consciously and unconsciously. The living body, quite on its own, bends every effort to maintain its living existence. The built-in impulses toward self-preservation and individual well-being that penetrate our consciousness, say, as hunger or fear of death, are manifestations of a deep-seated and powerful will-to-live. These thoughts might suggest that murder is wrong

³ Not all taking of human life is murder. Self-defense, war, and capital punishment have been moral grounds used to justify homicide, and it is a rare moralist who would argue that it is never right to kill another human being. Without arguing about these exceptions, we confine our attention to murder, which is, by definition, unjust or wrongful killing. Everyone knows it to be wrong, immediately and without argument. Rarely do we ask ourselves why.

This is, of course, as it should be. The most important insights on which decent society rests—e.g., the taboos against incest, cannibalism, murder, and adultery—are too important to be imperiled by reason’s poor power to give them convincing defense. Such taboos might themselves be the incarnation of reason, even as they resist attempts to give them logical demonstration: like the axioms of geometry, they might be at once incapable of proof and yet not in need of proof, i.e., self-evident to anyone not morally blind. What follows, then, is more a search for insight than an attempt at proof.

because it opposes this will-to-live, because it deprives another of life against his will, because it kills someone who does not *want* to die. This sort of reason would explain why suicide—self-willed self-killing—might be right, while murder—killing an innocent person against his will—would always be wrong.

Let us consider this view more closely. Certainly, there are some invasions or "violations" of another's body that are made innocent by consent. Blows struck in a boxing match or on the football field do not constitute assault; conversely, an unwelcome kiss from a stranger, because it is an unconsented touching, constitutes a battery, actionable at law. In these cases, the willingness or unwillingness of the "victim" alone determines the rightness or wrongness of the bodily blows. Similar arguments are today used to explain the wrongness of rape: it is "against our wills," a violation not (as we once thought) of womanliness or chastity or nature but of freedom, autonomy, personal self-determination. If consent excuses—or even justifies—these "attacks" on the body of another, might not consent excuse—or justify—the ultimate, i.e., lethal, attack, turning murder into mere (unwrongful) homicide? A person can be murdered only if he personally does not want to be dead.

There is something obviously troublesome about this way of thinking about crimes against persons. Indeed, the most abominable practices, proscribed in virtually all societies, are *not* excused by consent. Incest, even between consenting adults, is still incest; cannibalism would not become merely *delicatessen* if the victim freely gave permission; ownership of human beings, voluntarily accepted, would still be slavery. The violation of the other is independent of the state of the will (in fact, both of victim and perpetrator).

The question can be put this way: is the life of another human being to be respected only because that person (or society) *deems* or *wills* it respectable, or is it to be respected because it is *in itself* respectable? If the former, then human worth depends solely on agreement or human will; since will confers dignity, will can take it away, and a permission to violate nullifies the violation. If the latter, then one can never be freed from the obligation to respect human life by a request to do so, say, from someone who no longer values his own life.

This latter view squares best with our intuitions. We are not entitled to dismember the corpse of a suicide nor may we kill innocently those consumed by self-hatred. According to our law, killing the willing, the unwilling, and the non-willing (e.g., infants, the comatose) are all equally murder. Beneath the human will, indeed, the *ground* of human will, is something that commands respect and restraint, willy-nilly. We are to abstain from killing because of something

respectable about human beings as such. But what is it?

IN WESTERN societies, moral notions trace back to biblical religion. The bedrock of Jewish and Christian morality is the Ten Commandments. "Thou shalt not murder"—the sixth commandment—heads up the so-called second table, which enunciates (negatively) duties toward one's fellow man. From this fact, some people have argued that murder is wrong solely because God said so. After all, that He had to legislate against it might imply that human beings on their own did not know that it was bad or wrong. And even were they to intuit *that* murder is wrong, they might never be able to answer, if challenged, *why* it is wrong; this human inability to supply the reason would threaten the power of the taboo. Thus, so the argument goes, God's will supplies the missing reason for the human rule.

This argument is not satisfactory. True, divine authority elevates the standing and force of the commandments. But it does not follow that they "make sense" only because God willed them. Pagans yesterday believed and atheists today still believe that murder is wrong. In fact, the entire second table of the Decalogue is said to propound not so much divine law as natural law, law suitable for man as man, not only for Jew or Christian.

The Bible itself provides evidence in support of this interpretation, at least about murder. In reporting the first murder, committed by Cain upon his brother Abel before there was any given or known law against it, Abel's blood is said to cry out from the earth in protest against his brother's deed. (The crime, it seems, was a crime against blood and life, not against will, human or divine.) And Cain's denial of knowledge ("Am I my brother's keeper?") seems a clear indication of guilt: if there were nothing wrong with murder, why hide one's responsibility? A "proto-religious" dread accompanies the encounter with death, especially violent death.

But the best evidence comes shortly afterward, in the story of the covenant with Noah: the first law against murder is explicitly promulgated for all mankind united, well before there are Jews or Christians or Muslims. This passage is worth looking at in some detail because, unlike the enunciation of the sixth commandment, it offers a specific reason why murder is wrong.⁴

⁴ Non-religious readers may rightly express suspicion at my appeal to a biblical text for what I will claim is a universal or philosophical explanation of the taboo against murder. This suspicion will be further increased by the content of the text cited. Nevertheless, properly interpreted, I believe the teaching of the passage stands free of its especially biblical roots, and offers a profound insight into the ground of our respect for human life.

The prohibition of murder is part of the new order following the Flood. Before the Flood, human beings lived in the absence of law or civil society. The result appears to be something like what Hobbes called the state of nature characterized as a condition of war of each against all. Might alone makes right, and no one is safe. The Flood washes out human life in its natural state; immediately after the Flood, some form of law and justice is instituted, and nascent civil society is founded.

At the forefront of the new order is a newly articulated respect for human life,⁵ expressed in the announcement of the punishment for homicide:

Whoso sheddeth man's blood, by man shall his blood be shed; for in the image of God made He man. [Genesis 9:6]

Like law in general, this cardinal law combines speech and force. The threat of capital punishment stands as a deterrent to murder and hence provides a motive for obedience. But the measure of the punishment is instructive. By equating a life for a life—*no more than a life for a life*, and the life only of the murderer, not also of his wife and children—the threatened punishment implicitly teaches the *equal* worth of each human life. Such equality can be grounded only in the equal *humanity* of each human being. Against our own native self-preference, and against our tendency to overvalue what is our own, blood-for-blood conveys the message of universality and equality.

But murder is to be avoided not only to avoid the punishment. That may be a motive, which speaks to our fears; but there is also a reason, which speaks to our minds and our loftier sentiments. The fundamental reason that makes murder wrong—and that even justifies punishing it homicidally!—is man's divine-like status.⁶ Not the other fellow's unwillingness to be killed, not even (or only) our desire to avoid sharing his fate, but *his*—any man's—*very being* requires that we respect his life. Human life is to be respected more than animal life, because man is more than an animal; man is said to be god-like. Please note that the *truth* of the Bible's assertion does *not* rest on biblical authority: man's more-than-animal status is in fact performatively proved whenever human beings quit the state of nature and set up life under such a law. The law which establishes that men are to be law-abiding both insists on, and thereby demonstrates the truth of, the superiority of man.

How is man God-like? Genesis 1—where it is first said that man is created in God's image—introduces us to the divine *activities* and *powers*: (1) God speaks, commands, names, and blesses; (2) God makes and makes freely; (3) God looks at and beholds the world; (4) God is concerned with the goodness or

perfection of things; (5) God addresses solicitously other living creatures. In short: God exercises speech and reason, freedom in doing and making, and the powers of contemplation, judgment, and care.

Doubters may wonder whether this is truly the case about God—after all, it is only on biblical authority that we regard God as possessing these powers and activities. But it is certain that we human beings have them, and that they lift us above the plane of a merely animal existence. Human beings, alone among the earthly creatures, speak, plan, create, contemplate, and judge. Human beings, alone among the creatures, can articulate a future goal and bring it into being by their own purposive conduct. Human beings, alone among the creatures, can think about the whole, marvel at its articulated order, and feel awe in beholding its grandeur and in pondering the mystery of its source.

A complementary, preeminently moral, gloss on the "image of God" is provided—quite explicitly—in Genesis 3, at the end of the so-called second creation story:

Now the man is become *like one of us* knowing good and bad. . . . [3:22; emphasis added]⁷

Human beings, unlike the other animals, distinguish good and bad, have opinions and care about their difference, and constitute their whole life in the light of this distinction. Animals may suffer good and bad, but they have no notion of either. Indeed, the very pronouncement, "Murder is bad," constitutes proof of *this* god-like quality of human beings.

In sum, man has special standing because he shares in reason, freedom, judgment, and moral concern, and, as a result, lives a life freighted with moral self-consciousness. Speech and freedom are used, among other things, to promulgate moral rules and to pass moral judgments, first among which is that murder is to be punished in kind because it violates the dignity of such a moral

⁵ This respect for human life, and the self-conscious establishment of society on this premise, separates human beings from the rest of the animals. This separation is made emphatic by the institution of meat-eating (Genesis 9:1-4), permitted to men here for the first time. (One can, I believe, show that the permission to eat meat is a concession to human blood lust and voracity, not something cheerfully and happily endorsed.) Yet, curiously, even animal life must be treated with respect: the blood, which is identified as the life, cannot be eaten. Human life, as we shall see more clearly, is thus both continuous and discontinuous with animal life.

⁶ The second part of verse 6 seems to make two points: man is in the image of God (i.e., is god-like), and man was *made* thus by God. The decisive point is the first. Man's creatureliness cannot be the reason for avoiding bloodshed; the animals too were made by God, yet permission to kill them for food has just been given. The full weight rests on man's *being* "in the image of God."

⁷ In the first creation story, Genesis 1:2-3, man is created straightaway in God's likeness; in this second account, man is, to begin with, made of dust, and he *acquires* god-like qualities only at the end, and then only in transgressing

being. We note a crucial implication. To put it simply: the *sanctity* of human life rests absolutely on the *dignity*—the god-like-ness—of human beings.

Yet man is, at most, only godly; he is not God or a god. To be an image is also to be *different* from that of which one is an image. Man is, at most, a *mere* likeness of God. With us, the seemingly godly powers and concerns described above occur conjoined with our animality. We are also flesh and blood—no less than the other animals. God's image is tied to blood, which is the life.

The point is crucial, and stands apart from the text that teaches it: everything high about human life—thinking, judging, loving, willing, acting—depends absolutely on everything low—metabolism, digestion, respiration, circulation, excretion. In the case of human beings, “divinity” needs blood—or “mere” life—to sustain itself. And because of what it holds up, human blood—that is, human life—deserves special respect, beyond what is owed to life as such: the low ceases to be the low. (Modern physiological evidence could be adduced in support of this thesis: in human beings, posture, gestalt, respiration, sexuality, and fetal and infant development, among other things, all show the marks of the co-presence of rationality.) The biblical text elegantly mirrors this truth about its subject, subtly merging both high and low: though the *reason* given for punishing murder concerns man's *godliness*, the *injunction* itself concerns man's *blood*. Respect the god-like; do not shed its blood! Respect for anything *human* requires respecting *everything* human, requires respecting *human being* as such.

We have found, I believe, what we were searching for: a reason immanent in the nature of things for finding fault with taking human life, apart from the needs of society or the will of the victim. The wanton spilling of human blood is a violation and a desecration, not only of our laws and wills but of being itself.

We have also found the ground for repudiating the opposition between the sanctity of life and human dignity. Each rests on the other. Or, rather, they are mutually implicated, as inseparable as the concave and the convex. Those who seek to pull them apart are, I submit, also engaged in wanton, albeit intellectual, violence.

UNFORTUNATELY, the matter cannot simply rest here. Though the principle seems well established, there is a difficulty, raised in fact by the text itself. How can one assert the inviolability of human life and, in the same breath, insist that human beings deliberately *take* human life to punish those who shed human blood?²⁸ There are, it seems, sometimes good reasons for shedding human blood, notwithstanding that man is in God's image. We have admitted the dangerous principle: humanity, to uphold the

dignity of the human, must sometimes shed human blood.

Bringing this new principle to the case of euthanasia, we face the following challenge to the prior, and more fundamental, principle, shed no human blood: what are we to think when the continuing circulation of human blood no longer holds up anything very high, when it holds up little more—or even *no* more—than metabolism, digestion, respiration, circulation, and excretion? What if human godliness appears to be humiliated by the degradation of Alzheimer's disease or paraplegia or rampant malignancy? And what if it is the well-considered aspiration of the “god-like” to put an end to the humiliation of that very godliness, to halt the mockery that various severe debilities make of a *human* life? Are there here to be found other exceptions to our rule against murder, in which the dignity of a human life can (only?) be respected by ending it?

The first thing to observe, of course, is that the cases of euthanasia (or suicide) and capital punishment are vastly different. One cannot by an act of euthanasia deter or correct or obtain justice from the “violinist” of human dignity; senility and terminal illness are of natural origin and can be blamed on no human agent. To be precise, these evils may in their result undermine human dignity, but, lacking malevolent intention, cannot be said to insult it or deny it. They are reasons for sadness, not *indignation*, unless one believes, as the tyrant does, that the cosmos owes him good and not evil and exists to satisfy his every wish. Moreover, one does not come to the defense of diminished human dignity by finishing the job, by annihilating the victims. Human dignity would be no more vindicated by euthanizing patients with Alzheimer's disease than it would be by executing as polluted the victims of rape.

Nevertheless, the question persists, and an affirmative answer remains the point of departure for the active euthanasia movement. Many who fly the banner of “death with dignity” insist that it centrally includes the option of active euthanasia, especially when requested. In order to respond more adequately to this challenge, we need first a more careful inquiry into “death with dignity.”

²⁸ Does this mean that those who murder forfeit their claim to be humanly respected, because they implicitly have denied the humanity of their victim (and, thus, in principle, of their own—and all other—human life)? In other words, do men need to act in accordance with the self-knowledge of human godliness in order to be treated accordingly? Or, conversely, do we rather respect the humanity of murderers when we punish them, even capitally, treating them not as crazed or bestial but as responsible moral agents who accept the fair consequences of their deeds? Or is the capitalness of the punishment not a theoretical matter, but a practical one, intended mainly to deter by fear those whose self-love or will-to-power will not listen to reason? These are vexed questions, too complicated to sort out quickly, and, in any case, beyond the point of the present discussion. Yet the relevant difficulty persists.

Death With Dignity

THE phrase "death with dignity," whatever it means precisely, certainly implies that there are more and less dignified ways to die. The demand for death with dignity arises only because more and more people are encountering in others and fearing for themselves or their loved ones the deaths of the less dignified sort. This point is indisputable. The possibility of dying with dignity can be diminished or undermined by many things, for example, by coma or senility or madness, by unbearable pain or extensive paralysis, by isolation, by institutionalization or destitution, by sudden death, as well as by excessive or impersonal medical interventions directed toward the postponement of death. It is the impediments connected with modern medicine that increasingly arouse indignation, and the demand for death with dignity pleads for the removal of these "unnatural" obstacles.

More generally, the demand for autonomy and the cry for dignity are asserted against a medicalization and institutionalization of the end of life that robs the old and the incurable of most of their autonomy and dignity: intubated and electrified, with bizarre mechanical companions, confined and immobile, helpless and regimented, once proud and independent people find themselves cast in the roles of passive, obedient, highly disciplined children. Death with dignity means, in the first instance, the removal of these added indignities and dehumanizations of the end of life.

One can only sympathize with this concern. Yet even if successful, efforts to remove these obstacles would not yet produce a death with dignity. For one thing, not all obstacles to dignity are artificial and externally imposed. Infirmary and incompetence, dementia and immobility—all of them of natural origins—greatly limit human possibility, and for many of us they will be sooner or later unavoidable, the products of inevitable bodily or mental decay. Second, there is nothing of human dignity in the process of dying itself—only in the way we face it: at its best, death with complete dignity will always be compromised by the extinction of dignified humanity; it is, I suspect, a death-denying culture's anger about dying and mortality that expresses itself in the partly oxymoronic and unreasonable demand for dignity in death. Third, insofar as we seek better health and longer life, insofar as we turn to doctors to help us get better, we necessarily and voluntarily compromise our dignity: being a patient rather than an agent is, humanly speaking, undignified. All people, especially the old, willingly, if unknowingly, accept a whole stable of indignities simply by seeking medical assistance. The really proud people refuse altogether to submit to doctors and hospitals. It is well to be reminded of these limits on our ability to roll back the indignities that assault the dying, so that we might acquire more

realistic expectations about just how much dignity a "death-with-dignity" campaign can provide.

A death with positive dignity—which may turn out to be something rare, like a life with dignity—entails more than the absence of external indignities. Dignity in the face of death cannot be given or conferred from the outside but requires a dignity of soul in the human being who faces it. To understand the meaning of and prospects for death with dignity, we need first to think more about dignity itself, what it is.

Dignity is, to begin with, an undemocratic idea. The central notion, etymologically, both in English and in its Latin root (*dignitas*), is that of worthiness, elevation, honor, nobility, height—in short, of excellence or virtue. In all its meanings it is a term of distinction; dignity is not something which, like a nose or a navel, is to be expected or found in every living human being. Dignity is, in principle, aristocratic.

It follows that dignity, thus understood, cannot be demanded or claimed; for it cannot be provided and it is not owed. One has no more *right* to dignity—and hence to dignity in death—than one has to beauty or courage or wisdom, desirable though these all may be.

One can, of course, seek to democratize the principle; one can argue that "excellence," "being worthy," is a property of all human beings, say, for example, in comparison with animals or plants, or with machines. This, I take it, is what is often meant by "*human dignity*." This is also what is implied when one asserts that much of the terminal treatment of dying patients is dehumanizing, or that attachments to catheters, respirators, and suction tubes hide the human countenance and thereby insult the dignity of the dying. I myself earlier argued that the special dignity of the human species, thus understood, is the ground of the sanctity of human life. Yet on further examination this universal attribution of dignity to human beings pays tribute more to human potentiality, to the *possibilities* for human excellence. *Full* dignity, or dignity properly so-called, would depend on the *realization* of these possibilities. *Among* human beings, there would still be, on any such material principle, distinctions to be made. If universal human dignity is grounded, for example, in the moral life, in that everyone faces and makes moral choices, dignity would seem to depend mainly on having a *good* moral life, that is, on choosing well. Is there not more dignity in the courageous than in the cowardly, in the moderate than in the self-indulgent, in the righteous than in the wicked?⁹

⁹ This is not necessarily to say that one should treat other people, including those who eschew dignity, as if they lacked it. This is a separable question. It may be salutary to treat people on the basis of their capacities to live humanly, despite even great falling short or even willful self-degradation. Yet this would, in the moral sphere at least, require that we expect and demand of people that they behave worthily and that we hold them responsible for their own conduct.

But courage, moderation, righteousness, and the other human virtues are not solely confined to the few. Many of us strive for them, with partial success, and still more of us do ourselves honor when we recognize and admire those people nobler and finer than ourselves. With proper models, proper rearing, and proper encouragement, many of us can be and act more in accord with our higher natures. In these ways, the openness to dignity can perhaps be democratized still further.

In truth, if we know how to look, we find evidence of human dignity all around us, in the valiant efforts ordinary people make to meet necessity, to combat adversity and disappointment, to provide for their children, to care for their parents, to help their neighbors, to serve their country. Life provides numerous hard occasions that call for endurance and equanimity, generosity and kindness, courage and self-command. Adversity sometimes brings out the best in a man, and often shows best what he is made of. Confronting our own death—or the deaths of our beloved ones—provides an opportunity for the exercise of our humanity, for the great and small alike. Death with dignity, in its most important sense, would mean a dignified attitude and virtuous conduct in the face of death.

WHAT would such a dignified facing of death require? First of all, it would require knowing that one is dying. One cannot attempt to settle accounts, make arrangements, complete projects, keep promises, or say farewell if one does not know the score. Second, it requires that one remain to some degree an agent rather than (just) a patient. One cannot make a good end of one's life if one is buffeted about by forces beyond one's control, if one is denied a decisive share in decisions about medical treatments, institutionalization, and the way to spend one's remaining time. Third, it requires the upkeep—as much as possible—of one's familial, social, and professional relationships and activities. One cannot function as an actor if one has been swept off the stage and been abandoned by the rest of the cast. It would also seem to require some direct, self-conscious confrontation, in the loneliness of one's soul, with the brute fact and meaning of nearing one's end. Even, or especially, as he must be passive to the forces of decay, the dignified human being can preserve and reaffirm his humanity by seeing clearly and without illusion.¹⁰ (It is for this reason, among others, that sudden and unexpected death, however painless, robs a man of the opportunity to have a dignified end.)

But as a dignified human life is not just a lonely project against an inevitable death, but a life whose meaning is entwined in human relationships, we must stress again the importance for a death with dignity—as for a life with dignity—

of dignified human intercourse with all those around us. Who we are to ourselves is largely inseparable from who we are to and for others: thus, our own exercise of dignified humanity will depend crucially on continuing to receive respectful treatment from others. The manner in which we are addressed, what is said to us or in our presence, how our bodies are tended or our feelings regarded—in all these ways, our dignity in dying can be nourished and sustained. Dying people are all too easily reduced ahead of time to "thinghood" by those who cannot bear to deal with the suffering or disability of those they love. Objectification and detachment are understandable defenses. Yet this withdrawal of contact, affection, and care is probably the greatest single cause of the dehumanization of dying. Death with dignity requires absolutely that the survivors treat the human being at all times as if full god-likeness remains, up to the very end.

It will, I hope, now be perfectly clear that death with dignity, understood as living dignifiedly in the face of death, is not a matter of pulling plugs or taking poison. To speak this way—and it is unfortunately common to speak this way¹¹—is to shrink still further the notion of human dignity, and thus heap still greater indignity upon the dying, beyond all the insults of illness and the medicalized bureaucratization of the end of life. If it really is death with dignity we are after, we must think in human and not technical terms. With these thoughts firmly in mind, we can turn in closing back to the matter of euthanasia.

Euthanasia: Undignified and Dangerous

HAVING followed the argument to this point, even a friendly reader might chide me as follows: "Well and good to think humanistically, but tough practical dilemmas arise, precisely about the use of techniques, and they must be addressed. Not everyone is so fortunate as to be able to die at home, in the company of a loving family, beyond the long reach of the medical-industrial complex. How should these

¹⁰ The Homeric warriors, preoccupied with mortality and refusing to hide away in a corner waiting for death to catch them unawares, went boldly forward to meet it, armed only with their own prowess and large hearts: in facing death frontally, in the person of another similarly self-conscious hero, they wrested a human victory over blind necessity, even in defeat. On a much humbler scale, the same opportunity is open to anyone willing to look death in the face.

¹¹ A perfect instance is the recent California Initiative. It proposed amending the name of the existing California statute from "Natural Death Act" to "Humane and Dignified Death Act," but its only substantive change was to declare and provide for "the right of the terminally ill to voluntary, humane, and dignified doctor-assisted aid-in dying," "aid in dying" meaning "any medical procedure that will terminate the life of the qualified patient swiftly, painlessly, and humanely." A (merely) natural death is to be made "dignified" simply by having it deliberately produced by (dignified) doctors.

technical decisions—about respirators and antibiotics and feeding tubes and, yes, even poison—be made, precisely in order to uphold human dignity and the sanctity of life that you say are so intermingled?" A fair question: I offer the following outline of an answer.

About treatment for the actually dying, there is in principle no difficulty. In my book, *Toward a More Natural Science*, I have argued for the primacy of easing pain and suffering, along with supporting and comforting speech, and, more to the point, the need to draw back from some efforts at prolongation of life that prolong or increase only the patient's pain, discomfort, and suffering. Although I am mindful of the dangers and aware of the impossibility of writing explicit rules for ceasing treatment—hence the need for prudence—considerations of the individual's health, activity, and state of mind must enter into decisions of *whether* and *how vigorously* to treat if the decision is indeed to be for the patient's good. Ceasing treatment and allowing death to occur when (and if) it will, can, under some circumstances, be quite compatible with the respect that life itself commands for itself. For life can be revered not only in its preservation, but also in the manner in which we allow a given life to reach its terminus.

WHAT about so-called active euthanasia, the direct making dead of someone who is not yet dying or not dying "fast enough"? Elsewhere I have argued at great length against the practice of euthanasia by physicians, partly on the grounds of bad social consequences, but mainly on the grounds that killing patients—even those who ask for death—violates the inner meaning of the art of healing.¹² Powerful prudential arguments—unanswerable, in my view—have been advanced as to why legalized mercy killing would be a disastrous social policy, at least for the United States. But some will insist that social policy cannot remain deaf to cries for human dignity, and that dangers must be run to preserve a dignified death through euthanasia, at least where it is requested. As our theme here is dignity and sanctity, I will confine my answer to the question of euthanasia and human dignity.

Let us begin with voluntary euthanasia—the request for assistance in dying. To repeat: the claim here is that the choice for death, because a free act, affirms the dignity of free will against dumb necessity. Or, using my earlier formulation, is it not precisely dignified for the "god-like" to put a voluntary end to the humiliation of that very godliness?

In response, let me start with the following questions. Do the people who are actually contemplating euthanasia *for themselves*—as opposed to their proxies who lead the euthanasia movement—generally put their requests in these terms? Or are they not rather looking for a way to end

their troubles and pains? One can sympathize with such a motive, out of compassion, but can one admire it, out of respect? Is it really dignified to seek to escape from troubles for oneself? Is there, to repeat, not more dignity in courage than in its absence?

Euthanasia for one's own dignity is, at best, paradoxical, even self-contradictory: how can I honor myself by making myself nothing? Even if dignity were to consist solely in autonomy, is it not an embarrassment to claim that autonomy reaches its zenith precisely as it disappears? Voluntary euthanasia, in the name of positive dignity, does not make sense.

Acknowledging the paradox, some will still argue the cause of freedom on a more narrow ground: the prospect of euthanasia increases human freedom by increasing options. It is, of course, a long theoretical question whether human freedom is best understood—and best served—through the increase of possibilities. But as a practical matter, in the *present* case, I am certain that this view is mistaken. On the contrary, the opening up of this "option" of assisted suicide will greatly constrain human choice. For the choice for death is not one option among many, but an option to end all options. Socially, there will be great pressure on the aged and the vulnerable to exercise this option. Once there looms the legal alternative of euthanasia, it will plague and burden every decision made by any seriously ill elderly person—not to speak of their more powerful caretakers—even without the subtle hints and pressures applied to them by others.

And, thinking about others, is it dignified to ask or demand that someone else become my killer? It may be sad that one is unable to end one's own life, but can it conduce to either party's dignity to make the request? Consider its double meaning if made to a son or daughter: Do you love me so little as to force me to live on? Do you love me so little as to want me dead? What person in full possession of his own dignity would inflict such a duty on anyone he loved?

Of course, the whole thing could be made impersonal. No requests to family members, only to physicians. But precisely the same point applies: how can one demand care and humanity from one's physician, and, at the same time, demand that he play the role of technical dispenser of death? To turn the matter over to non-physicians, that is, to technically-competent professional euthanizers, is, of course, completely to dehumanize the matter.¹³

Proponents of euthanasia do not understand human dignity, which, at best, they confuse with

¹² "Neither for Love nor Money: Why Doctors Must Not Kill," *Public Interest*, Winter 1989, pp. 25-46.

¹³ For a chilling picture of the fully rationalized and technically managed death, see the account of the Park Lane Hospital for the Dying in Aldous Huxley's *Brave New World*.

humaneness. One of their favorite arguments proves this point: why, they say, do we put animals out of their misery but insist on compelling fellow human beings to suffer to the bitter end? Why, if it is not a contradiction for the veterinarian, does the medical ethic absolutely rule out mercy killing? Is this not simply inhumane?

Perhaps inhumane, but not thereby inhuman. On the contrary, it is precisely because animals are not human that we must treat them (merely) humanely. We put dumb animals to sleep because they do not know that they are dying, because they can make nothing of their misery or mortality, and, therefore, because they cannot live deliberately—i.e., humanly—in the face of their own suffering or dying. They cannot live out a fitting end. Compassion for their weakness and dumbness is our only appropriate emotion, and given our responsibility for their care and well-being, we do the only humane thing we can. But when a conscious human being asks us for death, by that very action he displays the presence of something that precludes our regarding him as a dumb animal. Humanity is owed humanity, not humaneness. Humanity is owed the bolstering of the human, even or especially in its dying moments, in resistance to the temptation to ignore its presence in the sight of suffering.

What humanity needs most in the face of evils is courage, the ability to stand against fear and pain and thoughts of nothingness. The deaths we most admire are those of people who, knowing that they are dying, face the fact frontally and act accordingly: they set their affairs in order, they arrange what could be final meetings with their loved ones, and yet, with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can. Because such conclusions of life require courage, they call for our encouragement—and for the many small speeches and deeds that shore up the human spirit against despair and defeat.

And what of non-voluntary euthanasia, for those too disabled to request it for themselves—the comatose, the senile, the psychotic: can this be said to be in the service of *their* human dignity? If dignity is, as the autonomy people say, tied crucially to consciousness and will, non-voluntary or "proxy-voluntary" euthanasia can never be a dignified act for the one euthanized. Indeed, it is precisely the absence of dignified humanity that invites the thought of active euthanasia in the first place.

Is it really true that such people are beneath all human dignity? I suppose it depends on the particulars. Many people in greatly reduced states still retain clear, even if partial, participation in human relations. They may respond to kind words or familiar music; they may keep up pride in their appearance or in the achievements of the grandchildren; they may take pleasure in reminiscences

or simply in having someone who cares enough to be present; conversely, they may be irritated or hurt or sad, even appropriately so; and, even nearer bottom, they may be able to return a smile or a glance in response to a drink of water or a change of bedding or a bath. Because we really do not know their inner life—what they feel and understand—we run the risk of robbing them of opportunities for dignity by treating them as if they had none. It does not follow from the fact that *we* would never willingly trade places with them that *they* have *nothing* left worth respecting.

BUT what, finally, about the very bottom of the line, say, people in a "persistent vegetative state," unresponsive, contorted, with no evident ability to interact with the environment? What human dignity remains here? Why should we not treat such human beings as we (properly) treat dumb animals, and put them out of "their misery"?¹⁴ I grant that one faces here the hardest case for the argument I am advancing. Yet one probably cannot be absolutely sure, even here, about the complete absence of inner life or awareness of their surroundings. In some cases, admittedly extremely rare, persons recover from profound coma (even with flat EEG); and they sometimes report having had partial yet vivid awareness of what was said and done to them, though they had given no external evidence of same. But beyond any restraint owing to ignorance, I would also myself be restrained by the human form, by *human blood*, and by what I owe to the full human life that this particular instance of humanity once lived. I would gladly stand aside and let die, say in the advent of pneumonia; I would do little beyond the minimum to sustain life; but I would not countenance the giving of lethal injections or the taking of other actions deliberately intending the patient's death. Between only undignified courses of action, this strikes me as the least undignified—especially for myself.

I have no illusions that it is easy to live with a Karen Ann Quinlan or a Nancy Cruzan or the baby Linares. I think I sufficiently appreciate the anguish of their parents or their children, and the distortion of their lives and the lives of their families. I also know that, when hearts break and people can stand it no longer, mercy killing will happen, and I think we should be prepared to excuse it—as we generally do—when it occurs in this way. But an excuse is not yet a justification, and very far from dignity.

¹⁴ Once again we should be careful about our speech. It may be a great source of misery for *us* to see them in this state, but it is not at all clear that *they feel or have* misery. Precisely the ground for considering them beneath the human threshold is that nothing registers with them. This point is relevant to the "termination-of-feeding" cases, in which it is argued (in self-contradiction) that death by starvation is both humane and not in these instances cruel: someone who is too far gone to suffer from a death-by-starvation is, to begin with, not suffering at all.

What then should we conclude, as a matter of social policy? We should reject the counsel of those who, seeking to drive a wedge between human dignity and the sanctity of life, argue the need for active euthanasia, especially in the name of death with dignity. For it is precisely the setting of fixed limits on violating human life that makes possible our efforts at dignified relations with our fellow men, especially when their neediness and disability try our patience. We will never be able to relate even decently to people if we are entitled always to consider that one option before us is to make them dead. Thus, when the advocates for euthanasia press us with the most heart-rending cases, we should be sympathetic but firm. Our response should be neither "Yes, for mercy's sake," nor "Murder! Unthinkable!" but "Sorry. No." Above all we must not allow ourselves to become self-deceived: we must never seek to relieve *our* own frustrations and bitterness over the lingering deaths of others by pretending that we can kill them to sustain *their* dignity.

Coda

THE ancient Greeks knew about hubris and its tragic fate. We modern rationalists do not. We do not yet understand that the project for the conquest of death leads only to dehumanization, that any attempt to gain the tree of life by means of the tree of knowledge leads inevitably also to the hemlock, and that the utter rationalization of life under the banner of the will gives rise to a world in which the victors live long enough to finish life demented and without choice. The human curse is to discover only too late the evils latent in acquiring the goods we wish for.

Against the background of enormous medical

success, terminal illness and incurable disease appear as failures and as affronts to human pride. We refuse to be caught resourceless. Thus, having adopted a largely technical approach to human life and having medicalized so much of the end of life, we now are willing to contemplate a final technical solution for the evil of human finitude and for our own technical (but unavoidable) "failure," as well as for the degradations of life that are the unintended consequences of our technical successes. This is dangerous folly. People who care for autonomy and human dignity should try rather to reverse this dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate goodbye-to-all-that contained in one final plea for poison.

The present crisis that leads some to press for active euthanasia is really an opportunity to learn the limits of the medicalization of life and death and to recover an appreciation of living with and against mortality. It is an opportunity to remember and affirm that there remains a residual human wholeness—however precarious—that can be cared for even in the face of incurable and terminal illness. Should we cave in, should we choose to become technical dispensers of death, we will not only be abandoning our loved ones and our duty to care; we will exacerbate the worst tendencies of modern life, embracing technicism and so-called humaneness where encouragement and humanity are both required and sorely lacking. On the other hand, should we hold fast, should we decline "the ethics of choice" and its deadly options, should we learn that finitude is no disgrace and that human dignity can be cared for to the very end, we may yet be able to stem the rising tide that threatens permanently to submerge the best hopes for human dignity.

Suicide Made Easy

The Evil of "Rational" Humaneness

Leon R. Kass

AMERICANS have always been a handy people. If know-how were virtue, we would be a nation of saints. Unfortunately, certain old-fashioned taboos—brought to you by the people who know the difference between virtue and dexterity—have prevented Americans from gaining the ultimate know-how, the know-how to die. Until now. Riding atop the best-seller lists, outdistancing other manuals of self-help like *The Seven Habits of Highly Effective People*, *The T-Factor Fat Gram Counter*, and *Wealth Without Risk*, is Derek Humphry's latest book, *Final Exit*,* subtitled "The Practicalities of Self-Deliverance and Assisted Suicide for the Dying." Know-how in spades.

What can one say about this new "book"? In one word: evil. I did not want to read it, I do not want you to read it. It should never have been written, and it does not deserve to be dignified with a review, let alone an article. Yet it stares out at us from nearly every bookstore window, beckoning us to learn how to achieve the final solution—for ourselves or for those we (allegedly) love so much that we will help them kill themselves. Says the Lord High Executioner, Derek Humphry, prophet of Hemlock: I have set before thee life and death: therefore choose death. "Courageous," bleat the media; "Timely," "Rational," "Humane." Is there no one who will call evil by its proper name?

This is not the usual and notorious evil of malicious intent or violent manner; this is humanitarian evil, evil with a smile: well-meaning, gentle, and rational, especially rational. For this reason it is both harder to recognize as evil and harder to combat. Yet, also for this reason, it deserves our most vigilant attention, for it is an exquisite model of modern rationalism gone wrong, while looking oh so right.

Duty requires a few words about the contents of the book. Following an introduction which tells us that the book is "aimed at helping the public and the health professional achieve death

with dignity for those who desire to plan for it," the (longer) first of two parts is addressed to the public and especially those interested in "exiting." Here there are 22 chapters guiding the gentle reader ever so gently, step by step, into that gentle good night, from "The Most Difficult Decision" (a mere 3½ pages, ending with "Once these documents [Living Will and Durable Power of Attorney] are completed you are ready to tackle the other aspects of bringing your life to an end"), through (among others) "Shopping for the Right Doctor," "Beware of the Law," "Storing Drugs," "Who Shall Know?," "Insurance," "Letters to Be Written," and "Self-Deliverance Via the Plastic Bag," all leading up to "The Final Act," complete with detailed instructions for doing the deadly deed. Chapter 23 provides a check list of 16 items, after which drug-dosage tables are supplied for eighteen effective drugs. A shorter second part, addressed to doctors and nurses eager to assist, concludes with a short pharmacopoeia, rich in detail and editorial advice. A brief (and one-sidedly pro-death) bibliography, the text of the Hemlock Society's Model Death with Dignity Act, and brief notes about the author and the Hemlock Society conclude the book, save for a copious index from Aalgin to Zyklon-B gas.

DEREK HUMPHRY, who assisted in the suicide of his first wife (though it was a felony), and who (along with his second wife, Ann Wickett) founded the Hemlock Society in 1980, has been the country's leading spokesman and protagonist for euthanasia in all its forms. A journalist by profession, a euthanist by conviction, a diligent student and publicist, he has researched far and wide in preparing this most handy guide. Yet it is not so much his knowledge but his character that makes him a man for modern times.

Consider his virtues. *Up to date*: "Aren't these archaic laws [against assisting suicide] ready to be changed to situations befitting modern understanding and morality?" *Progressive*: "Now is the time to go one step further. *Final Exit* . . . is a book for the 1990's. As a society we have moved on." *Clean and collegial*: "This method [shoot-

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* The Hemlock Society, 192 pp., \$16.95

ing] is not favored by the euthanasia movement because it is messy (who cleans up?) and it has to be a lonely act, the opposite of the right-to-die credo, which aims to share the dying experience." *High-minded*: "A method for which I have respect is freezing to death on a mountain. It takes a certain sort of person to wish to die this way: determined, having knowledge of the mountains, and an enduring courage to carry it off." *Thorough*: "Make two copies of this [suicide] note because the police or coroner, if they become involved, will take the top copy and your survivors or attorney will need a copy also." *Considerate*: "Self-destruction by hanging is almost always an act of protest, a desire to shock and hurt someone. . . . Even if it is left to a policeman or paramedic to cut the corpse down, I still think this is an unacceptably selfish way to die." *Orderly*: "If you are now comfortable with the decision to die . . . you should review the following list." (The check list of 16 items follows, concluding with the injunction, "Leave nothing to chance.") *Respectful of competence*: "Unless you are an ingenious and accomplished engineer, electricity is definitely not advised for self-deliverance." *Gracious*: "If you are unfortunately obliged to end your life in a hospital or motel, it is gracious to leave a note apologizing for the shock and inconvenience to the staff. I have also heard of an individual leaving a generous tip to a motel staff." *Cheerful*: "Remember, life is well worth living to its fullest extent"—a homily that wanders illogically into a paragraph about how to achieve long-term storage of your lethal drugs. *Folksy*: "[A television program] featured a member who kept her 'insurance' in a hat box in her closet. That is as good a place as any." *Open-minded*: "Should you use a clear plastic bag or an opaque one? That's a matter of taste. Loving the world as I do, I'll opt for a clear one if I have to." *Helpful to the handicapped*: "As many of the readers of this book will be people with poor sight, it has been set in large type (14-point Dutch Roman type) to assist them." *Resourceful*: "[I]t is always worth an inspection of your medicine cabinet for any barbiturates left over from previous illnesses suffered by you or your family." *Balanced*: "While the Nazi motives were barbarous, ruthless, and unforgivable, the actual deaths [with cyanic acid gas] were swift, though this is small consolation to the families of the killed." *Meticulous*: "Make sure you have absolute privacy for up to eight hours. A Friday or Saturday night is usually the quietest time; there are generally no business transactions until Monday." *Technically precise*: "To compensate for this possible shortfall in toxicity, add one extra capsule or tablet to every ten of the recommended lethal dose." *Tolerant*: "If you consider God the master of our fate, then read no further. Seek the best pain management available and arrange hospice care"; or, "Pious persons may believe in medical miracles and that is their right." *Forthcomingly frank*: "If I ever need to end my own

life because of terminal suffering, whether I employed the most potent drugs or the less so, I would still use the plastic bag technique. If you are repulsed by the addition of the plastic bag, then you must accept a 10-percent chance that by some quirk you will wake up, and will have to try again. With the bag, it is 100-percent certain." *Non-directive*: "I am extremely careful not to offer an opinion, but let myself merely be a sounding board, a sympathetic ear"; but also *Authoritative*: "It is imperative that your loved ones know what you are contemplating." *Financially shrewd*: "My advice is that if you are considering self-deliverance from a terminal illness, look at the dates of your [insurance] policies. If they are more than two years old, your family is safe." *Morally superior*: "A nurse who wishes to participate in the euthanasia process should become well versed in the ethics and law of euthanasia particularly as applied in the applicable county, state, professional organization and institution. [But] to know the rules does not necessarily require obedience if there is an overriding moral imperative" (emphasis added); or, "Never join in the slightest attempt to persuade a dying person to end life. . . . Many laws are specific about the criminality of 'counseling and procuring' a suicide. In any event, it is ethically a wrong thing to do" (emphasis added). Question: why is it considered an act of the greatest love and friendship to assist in doing what it is immoral to counsel? Why, if "self-deliverance" is really "in my best interests," should not my true friends be praised for helping me to see it?)

ABOVE all, the author is calm, cool, and collected, and marvelously matter-of-fact. His confident voice of experience guides us through every step of the process, allaying anxieties, dispelling doubts, showing us exactly how-to-do-it. Adopting a tone and manner midway between the Frugal Gourmet and Mister Rogers, Humphry has written a book that reads like "A Salt-Free Guide to Longer Life" or "How to Conquer Fear in Twenty-two Easy Lessons." The reader, blinded by blandness, nearly loses sight of the big picture: this self-appointed messiah is indiscriminately and shamelessly teaching suicide (and worse) to countless strangers.

Humphry sanctimoniously insists that his book is not intended for everyone.* He intends, he avers, to be helpful only to those who are (or will be) terminally ill and who wish a quiet release from

* Just after I wrote this sentence, in an eerie coincidence, a telephone call informed me of the suicide of Derek Humphry's (divorced) second wife, an act which he apparently deplored. In a display of despicable shamelessness, Humphry took out a quarter-page ad in the *New York Times* (October 14, 1991) distancing himself and the Hemlock Society from such "irrational suicides." He neglected to mention his earlier penchant for distance: two years ago, he abandoned and divorced this woman when she was diagnosed as having cancer.

pain, suffering, or indignity. He even publishes a "Euthanizer-General's Warning"—but buries it in the footnotes to the drug-dosage table on the last page of Part I, after all the lethal instructions have been given—telling us that "this information is meant for consideration only for a *mature adult who is dying* and wishes to know about self-deliverance." His concern for the others is touching, if brief:

ADVICE:

If you are considering taking your life because you are unhappy, cannot cope, or are confused please do not read this table but contact a Crisis Intervention Center or Suicide Prevention Center. (Look in the telephone book. It may be under "Hotlines.") *An unfinished life is a terrible thing to waste.* [Emphasis added.]

Whom are we kidding? Every since Socrates' attack on writing, everyone knows that one cannot control who reads what is written or what is done with it. Only a fool could believe—and only a knave would pretend—that Humphry's instructions will be heeded only by the desperately dying or that his belated, brief, and saccharine advice to the depressed will lead them to re-embrace their precious unfinished lives.

The Centers for Disease Control have just reported that one in twelve American high-school students (grades 9-12)—or nearly 276,000 teenagers—tried to commit suicide in 1990, and more than one in four seriously contemplated it. Of those attempting, one in four—2 percent of the entire population—sustained serious injuries. (The rate of "successful" suicide attempts is roughly eleven deaths per 100,000 students, or 365 teenage suicides per year.) Thanks to Derek Humphry's book, our youth need no longer fail. Though the drugs he recommends require a doctor's prescription, they are, in fact, ubiquitous and easily available, as he surely knows ("Inspect your medicine cabinet for any barbiturates left over . . ."). And thanks to his instructions about sleeping pills, alcohol, and the proper way to use plastic bags, successful "self-deliverance" is available to anyone who can read—or who has a "loving friend" who can read. Even if only one teenager is now helped to suicide, Derek Humphry will have a lot to answer for.

Humphry has no intention of aiding poisoners, any more than he wishes to improve the suicide rate of the young. But he is, here too, equally naive, reprehensibly so. He is not so innocent as to be unaware of the danger, and in one (but only one) brief sentence—buried in the chapter on secrecy, "A Private Affair?"—makes a dashing display of his eagerness to prevent foul play: "I do not propose to name the drugs which are hard to trace because that information could possibly aid people with evil intent toward the lives of others." But such people need not have evil intent: they could be merely compassionate toward senile

Aunt Agatha—or just tired of visiting her or of paying the medical and nursing bills. Anyone with homicidal intent has been taught more lethal pharmacology than he ever needs to know—and also how to avoid detection. Just two pages before this pious refusal to help the wicked, Humphry has counseled the aiders-in-dying to refuse permission for autopsy, in order that death might pass as from "natural causes."

EVEN ignoring the intenders-of-evil, the teenagers, and the others whom Humphry excludes from his audience because they are "emotional," not "rational," it is perfectly clear that his intended readership is in fact much broader than the now or soon-to-be terminally ill. In a chapter on "The Dilemma of Quadriplegics," he embraces the principle of self-determination, terminal disease or not: "I respect the right of that small number of quadriplegics who want—either now or in the future—to have self-deliverance without being preached to and patronized by those on the religious Right." Not just terminal cancer but *any* sort of illness can qualify: "Nobody wants to die, yet life with an incurable or degenerative illness can be unacceptable for some people. Therefore, death is the preferred alternative" (emphasis added).

The elderly or the infirm or the demented or the blind—and, presumably, also the lonely or the humbled or the unwanted—are also on Humphry's compassionate and philanthropic mind: "I am not for one moment advocating that elderly people, or patients with degenerative diseases, should take their lives. It is *too personal* a decision" (emphasis added). Advocacy no, able assistance yes. On the very same page, Humphry coins a new term to cover those who, alas, have no fatal disease to carry them off—"what I call 'terminal old age'"—a euphemism that can now justify death for the not-dying.

Nor is Humphry shy about facilitating euthanasia for people with Alzheimer's disease: "There is a trend in the euthanasia movement to legislate only for physician aid-in-dying for the terminal patient who is rational. . . . But I believe that to duck responsibility for the incompetent patient is a serious gap in our humanitarian cause." Today the rational and terminal, tomorrow the blind and the lame, the deaf and the dumb: let there be nothing but compassion (and "aid-in-dying") for those who choose death—and even for those poor "incompetents" whose debility or loss of dignity convinces us that they *would* choose death had they only mind enough to do so. Thus does the right to choose one's own death become quickly mixed up with the right to "choose" someone else's.

One cannot exaggerate the importance of this difficulty, for it is buried by sloppy reasoning and by the (yes) emotional appeal of the insistence on choice. If suicide (and its assistance) is to be

justified by a right to choose the time and manner of one's death, if the right of life, liberty, and the pursuit of happiness or the so-called right of privacy encompasses also a "right to die," then (as Humphry argues) the whole matter is "too personal" and subjective; and the case for suicide need not rest on any objective or demonstrable criteria—such as certifiable terminal illness or truly intractable pain. For who is to say what makes life "unbearable," or death "electable," for another person? The autonomy argument kicks out all criteria for evaluating the choice, save that it be uncoerced.

Of course no one, not even Humphry, wants to leave it at that. Instead, reasons are given to justify choosing death: too much pain, loss of dignity, lack of self-command, poor quality of life. These are supposed to add up to a plausible verdict: life is no longer worth living. Such "useless" or "degrading" or "dehumanized" lives now plead for active, "merciful" termination—*choice* or *no choice*.

THE line between voluntary and non-voluntary (or involuntary) euthanasia cannot hold in practice, not least because it cannot be sustained in theory. Once suicide and assisting suicide are okay, for reasons of "mercy," then delivering the dehumanized is okay, whether chosen or not. Humphry and his crowd are well aware of the slippery slope. Yet pretending to want only a partial slide, they have both embraced the principle and started us on a decline that will take us all the way—to eliminating everyone deemed unfit.

This is already happening in Holland, as we are now beginning to discover. Humphry, like many other enthusiastic euthanists, touts the Dutch experience of physician-assisted suicide and treats it as a model, presenting a disingenuously rosy picture of the practice.* But the newly emerging truth should help restore sanity. In a recent book, *Regulating Death*,† Carlos S. Gomez reports that the practice in fact ignores virtually all the self-imposed guidelines and standards imposed by the Netherlands Medical Society: physicians sometimes do not seek a second opinion before administering death; they do not report the deed or even note it on the death certificate; where they do report euthanasia, no one investigates the facts; where someone does investigate, the physician controls all the evidence; and—quite clearly—they euthanize some patients who have *not* requested death. The practice is utterly unregulated—no big surprise to anyone who has given the matter any forethought.

Even more alarming is the newly released report of the government's Committee to Investigate the Practice of Euthanasia in Holland.** The report contains the most extensive and most reliable information to date on euthanasia in the Nether-

lands. Its reassuring conclusions are, to say the least, at great variance with the wealth of disturbing data it provides. Here are just a few of the findings: 25,300 cases of euthanasia (active and passive) occur in the Netherlands every year, 19.4 percent of all deaths in the country. These include 1,000 cases of *direct active involuntary* euthanasia. In addition, there are 8,100 cases in which morphine was overdosed with the intention to terminate life, 61 percent of the time without the patient's knowledge or consent. And there are another 8,750 cases in which life-preserving treatment was stopped or withheld without consent of the patient and with the intention to shorten life. "Low quality of life," "no prospect of improvement," and "the family could not take it anymore" were among the most frequently cited reasons to terminate patients' lives without their consent. In 45 percent of cases in which the lives of hospital patients were actively terminated without their consent, this was done without the knowledge of the families. Are you duly reassured? Hail to the Dutch, says Uncle Derek.

Hail also Dr. Jack Kevorkian, inventor of the suicide machine and self-appointed father of "obituary," the doctoring of death. Humphry gives him ten pages, the longest chapter in the book, and praises him for "notable public service by forcing the medical profession to rethink its attitude on euthanasia." Having been present at Dr. Kevorkian's civil trial—I was a witness for the state on matters of medical ethics—and having read his testimony, watched his demeanor in court, read letters in which he promised to "help" a woman who later was found to be suffering merely from treatable migraine, and, above all, having seen the self-serving and manipulative videotape he made of his only conversation with the unfortunate Janet Adkins the day before he helped her to "self-deliver," I feel the deepest shame for my profession that he should be counted a member.

But what does Humphry know or care about medical ethics or the meaning of permission to kill for the doctor-patient relationship? He celebrates the new age in which "physicians are now more likely to be seen as 'friendly body technicians.'" Though he acknowledges the right of individual physicians to abstain for *personal* reasons from assistance-in-suicide, he has absolutely no idea of a *professional ethic* as such, or of why for several thousand years, doctors have vowed

* Euthanasia and assisting suicide are still illegal in Holland, but the authorities have decided not to enforce the law. Here at home, happy reports about the Dutch practice played a large part in a campaign to make the state of Washington the first jurisdiction actively to legalize killing-on-request practiced by physicians.

† The Free Press, 172 pp., \$19.95.

** Portions of the report have been translated for me by Dutch acquaintance.

neither to give nor suggest a deadly drug, not even if asked for it.*

True enough, many physicians fall far short of the professional ideal; many lack empathy or rely too heavily on technology. But will it really restore the ethical dimension constitutive of the profession if we permit doctors to become technical dispensers of death? What will happen to the doctor's unswerving allegiance to the patient's best interests once he is entitled to start thinking that death by injection is a possible "treatment option"? Drunk on what passes for compassionate caring, Humphry does not truly care.

Two further passages show his colors. In the first, Humphry helpfully drafts a model suicide note, to be written and signed as "your last letter." Here are the last letter's last words:

If I am discovered before I have stopped breathing, I forbid anyone, including doctors or paramedics, to attempt to revive me. *If I am revived, I shall sue anyone who aided in this.* [Emphasis added.]

Compassionate words, intended to soften the blow when one finds one's loved one a suicide?

In the second vignette, concerning physician-and-nurse-assisted suicide, Humphry insists that the entire medical team must be informed about time and manner of the planned death. Why? Because "while everything must be done to reduce the stress on the medical team, a degree of emotional involvement in the dying of the patient is eminently worthwhile to *preserve an appreciation of the inherent sanctity of life*" (emphasis added). What kind of man would use "the inherent sanctity of life," no less, as a club to browbeat possibly reluctant nurses or doctors into participating in plans to kill?

No discussion of this book, especially in this magazine, could be complete without commenting on Humphry's respect for the fine work of his German counterparts, expressed at length in the chapter, "The Cyanide Enigma." After a (single) paragraph condemning the Nazi atrocities (but appreciating the swiftness of death by their Zyklon-B), Humphry rehabilitates the German euthanasia of the present day:

In the 1980's, the situation with regard to the suffering of terminally ill people was as tragic in Germany as elsewhere. Regardless of the terrible connotation given to the word "euthanasia" (which means help with a good death) by the Nazi atrocities, some people felt that compassionate action to help the dying was needed. In 1980, a pro-euthanasia society was formed, *Deutsche Gesellschaft Für Humanes Sterben* (German Society for Humane Dying), by a small group of brave people under the leadership of Hans Henning Atrott.

Unlike other countries, DGHS found it did not need to campaign for a change in the law on assisted suicide. There was no legal prohibition on helping another to die in justified circumstances so long as the request for help was clear and convincing.

The favorite method of DGHS is cyanide; Humphry, though he professes skepticism about peaceful death with cyanide, describes the German technique in minute detail, dosages included. He then goes on to praise "the simple cleverness of the DGHS method," which obviates the need for Zyklon-B gas by having the gas's active ingredient produced in the stomach following ingestion of potassium cyanide in water. Is not German science splendid? Does the high priest of euthanasia think that we have forgotten how to shudder?

LET me not be misunderstood. Dying in our technological age, even in humanitarian institutions, often comes attended by horrors unknown to our ancestors, often as an unintentional consequence of medical success in the battle against death. Medicine or no medicine, mortality remains our lot. Yet our secular and utopian culture does not prepare us well to face this truth and its consequences. Both painful personal experience and serious study for over two decades have taught me to appreciate deeply the anguish and fear of patients and families in the myriad matters surrounding decay and death; I know and feel the horror of the way many of us now end our lives. There are many, many circumstances—too numerous, too particular, too nuanced to lay out in advance—that call for the cessation of medical intervention, even if death comes as a result. There is rarely a good reason for withholding proper doses of pain medication, even if providing effective analgesia runs an increased risk of earlier death. And there is much more that we can do—most of it a matter of human relations, not of technological devices—to support the morale and dignity of people faced with incurable or fatal illness.† But to cross the line and accept active euthanasia, mercy killing, "aid-in-dying," death from doctor's healing hand, "dignified autoeuthanasia," and "self-deliverance"—that way lies madness.

At the very least, we must now open our eyes to the situation before us. We must not allow ourselves to be gulled by euphemisms and by falsely calming images like "final exit." We must not accept Humphry's shallow notion that "dignity" can be delivered by a hypodermic needle filled with lethal medicine. We must not forget the cost-containers and the eugenicists who stand ready in the wings to exploit the "choice" for death, to make sure that the burdensome and incurable take advantage of the deadly option.**

* See my essay, "Neither For Love Nor Money: Why Doctors Must Not Kill," *Public Interest*, Winter 1989.

† See my essay, "Death With Dignity & the Sanctity of Life," *COMMENTARY*, March 1990.

** There is not a word in this book about the current economic crisis in health care and the pressures that already throw people with chronic illness prematurely out of the hospital. The partisans of "right to die" and the partisans of "cut the costs" strange bedfellows, are incubating a deadly outcome for the vulnerable, the elderly, and the powerless.

And, above all, we must not fall for the calm and matter-of-fact talk of "rational suicide."

Calmness and coolness are, by themselves, no proof of rationality. Neither is deliberate planning, or the stockpiling of "magic pills." All human conduct is motivated—by desire or fear or some other appetite or emotion; thought alone moves nothing. However much Humphry talks of rationality—"It was not done out of cowardice or escapism but from long-held rational beliefs"; "Very, very few physicians will prescribe a lethal dose for a fit person. The stigma of being associated with a possible emotional suicide (as distinct from a rational suicide) is too risky"; etc.—the truth is that passions, sentiments, desires drive our every action. In the case of those explicitly addressed by this book, the dominant motives—the true movers of the soul—will be fear, resignation, and despair, or, in other words, the desire to escape. It is surely not pure reason that finds life unbearable.

Let's get serious about "rationality" and reason. Do we know what we are talking about when we claim that someone can *rationally* choose non-being or nothingness? How can poor reason even contemplate nothingness, much less accurately calculate its merits as compared with continued existence? What we have in so-called rational suicide is a mere rationality of means, rationality of technique, but utter *non-rationality* regarding the end and its putative goodness. An act of "rational suicide" may be psychologically understandable and (even, in some cases) morally pardonable, but it is utterly *unreasonable*.

Humphry and others contend that it is religious dogma alone, not human reason, which regards suicide as unethical. But this is patent nonsense. Immanuel Kant, whose claim to rationality is second to none, regarded the will to suicide as inherently self-contradictory, and thus, precisely, irrational:

It seems absurd that a man can injure himself (*volenti non fit injuria* [Injury cannot happen to one who is willing]). The Stoic therefore considered it a prerogative of his personality as a wise man to walk out of this life with an undisturbed mind whenever he liked (as out of a smoke-filled room), not because he was afflicted by actual or anticipated ills, but simply because he could make use of nothing more in this life. And yet this very courage, this strength of mind—of not fearing death and of knowing of something which man can prize more highly than his life—ought to have been an ever so

much greater motive for him not to destroy himself, a being having such authoritative superiority over the strongest sensible incentives; consequently, it ought to have been a motive for him not to deprive himself of life.

Man cannot deprive himself of his personhood so long as one speaks of duties, thus so long as he lives. That man ought to have the authorization to withdraw himself from all obligation, i.e., to be free to act as if no authorization at all were required for this withdrawal, involves a contradiction. To destroy the subject of morality in his own person is tantamount to obliterating from the world, as far as he can, the very existence of morality itself; but morality is, nevertheless, an end in itself. Accordingly, to dispose of oneself as a mere means to some end of one's own liking is to degrade the humanity in one's person (*homo noumenon*), which, after all, was entrusted to man (*homo phaenomenon*) to preserve.

So-called "rational suicide" is finally a sophism. Those who preach it and abet it are teachers of evil.

MODERN rationalism, whose leading branch is modern natural science and whose purest fruit is medical technology, has certainly made human life less poor, brutish, and short. Yet because, being morally neutral, it knows only the means, never the end, it has left us lost at sea without a compass. Worst of all, blinded by pride in our technique, we do not even suspect that we are lost, that we have become, as Churchill put it, "the sport and presently the victim of tides and currents, whirlpools and tornadoes among which [we are] far more helpless than [we have been for a long time]." We do not yet understand that the project for the mastery of nature and the conquest of death leads only to dehumanization: that any attempt to gain the tree of life by means of the tree of knowledge leads inevitably also to the hemlock; and that the utter rationalization of life under the banner of the will tragically produces a world in which we all get to become senile and in which our loved ones get to do us in.

The taboos against homicide, suicide, and euthanasia—like those against incest, adultery, and fornication, central insights of the receding wisdom from a more sensible age—are today weak and increasingly defenseless against the rising tide of gentle dehumanization. Yet they are all that stands between us and the flood. Everyone who cares truly for human dignity and decency—this is, everyone who would be truly rational—must now come to their defense, before it is too late.

**"I WILL GIVE
NO DEADLY DRUG"
WHY DOCTORS
MUST NOT KILL**

BY LEON R. KASS, MD, WASHINGTON, DC

I S THE PROFESSION OF MEDICINE ETHICALLY NEUTRAL? IF SO, WHENCE SHALL WE DERIVE THE MORAL NORMS OR PRINCIPLES TO GOVERN ITS PRACTICES? IF NOT, HOW ARE THE NORMS OF PROFESSIONAL CONDUCT RELATED TO THE REST OF WHAT MAKES MEDICINE A PROFESSION?

Editor's note: *The following article was presented as the American College of Surgeons Lecture on Ethics and Philosophy, which was inaugurated on October 23, 1991, in Chicago, IL. A slightly different version of this article was previously published as "Neither For Love Nor Money: Why Doctors Must Not Kill," in The Public Interest, Winter, 1989.*

These difficult questions, now much discussed, are in fact very old, indeed as old as the beginnings of Western medicine. According to an ancient Greek myth, the goddess Athena procured two powerful drugs in the form of blood taken from the Gorgon Medusa, the blood drawn from her left side providing protection against death, that from her right side a deadly poison. According to one version of the myth, Athena gave Asklepios, the revered founder of medicine, vials of both drugs; according to the other version, she gave him only the life-preserving drug, reserving the power of destruction for herself. There is force in both accounts: the first attests to the moral neutrality of medical means, and of technical power generally; the second shows that wisdom would constitute medicine an unqualifiedly benevolent—that is, intrinsically ethical—art.

Today, we doubt that medicine is an intrinsically ethical activity, but we are quite certain that it can both help and harm. In fact, today, help and harm flow from the same vial. The same respirator that brings a man back from the edge of the grave also senselessly prolongs the life of an irreversibly comatose young woman. The same morphine that reverses the respiratory distress of pulmonary edema can, in higher doses, arrest respiration altogether. Whether they want to or not, doctors are able to kill—quickly, efficiently, surely. And what is more, it seems that they may soon be licensed and encouraged to do so.

Last year in Holland, some 5,000–10,000 pa-

tients were intentionally put to death by their physicians, while authorities charged with enforcing the law against homicide agreed not to enforce it. Not satisfied with such hypocrisy, and eager to immunize physicians against possible prosecution, American advocates of active euthanasia are seeking legislative changes in several states that would legalize so-called mercy killing by physicians. And American medicine shows increasing signs that it may be willing to participate. Four years ago the editor of the *Journal of the American Medical Association* published an outrageous (and perhaps fictitious) case of mercy killing, precisely to stir professional and public discussion of direct medical killing—perhaps, some then said, as a trial balloon.¹ Since then, we have had Dr. Kevorkian's suicide-machine and Dr. Quill's published account of suicide-assistance, the latter especially drawing considerable medical support. So-called active euthanasia practiced by physicians seems to be an idea whose time has come. But, in my view, it is a bad idea whose time must not come—not now, not ever. This article is, in part, an effort to support this conclusion. But it is also an attempt to explore the ethical character of the medical profession, using the question of killing by doctors as a probe. Accordingly, I will be considering these interrelated questions: What are the norms that all physicians, as physicians, should agree to observe, whatever their personal opinions? What is the basis of such a medical ethic? What does it say—and what should we think—about doctors intentionally killing?

I. CONTEMPORARY ETHICAL APPROACHES

The question about physicians killing is a special case of this general question: May or ought one kill people who ask to be killed? Among those who answer this general question in the affirmative, two reasons are usually given. First is the reason of *freedom* or *autonomy*. Each person has a right to control his or her body and his or her life, including the end of it. On this view, physicians (or others) are bound to acquiesce in demands not only for termination of treatment but also for intentional killing through poison, because the right to choose—freedom—must be respected, even more than life itself, and even when the physician would never recommend or concur in the choices made. Physicians, as keepers of the vials of life and death, are morally bound actively to dispatch the embodied person, out of deference to autonomous personal choice.

The second reason for killing the patient who asks for death has little to do with choice. Instead, death is to be directly and swiftly given because the patient's life is deemed no longer worth living, according to some substantive or "objective" measure. Unusually great pain or a terminal condition or an irreversible coma or advanced senility or extreme degradation is the disqualifying quality of life that pleads—choice or no choice—for merciful termination. It is not his or her autonomy but rather the miserable and pitiable condition of the body or mind that justifies doing the patient in. Absent such substantial degradations, requests for assisted death would not be honored. Here the body itself offends and must be plucked out, from compassion or mercy, to be sure. Not the autonomous will of the patient, but the doctor's benevolent and compassionate love for suffering humanity justifies the humane act of mercy killing.

As I have indicated, these two reasons advanced to justify the killing of patients corre-

spond to the two approaches to medical ethics most prominent in the field today: the school of autonomy and the school of general benevolence and compassion (or love). Despite their differences, they are united in their opposition to the belief that medicine is intrinsically a moral profession, with *its own* immanent principles and standards of conduct that set limits on what physicians may properly do. Each seeks to remedy the ethical defect of a profession seen to be in itself amoral, technically competent but morally neutral.

For the first ethical school, morally neutral technique is morally used only when it is used according to the wishes of the patient as client or consumer. The model of the doctor-patient relationship is one of contract: the physician—a highly competent hired syringe, as it were—sells his or her services on demand, restrained only by the law. Here's the deal: for the patient, autonomy and service; for the doctor, money, graced by the pleasure of giving the patient what he wants. If a patient wants to fix her nose or change his gender, determine the sex of unborn children, or take euphoriant drugs just for kicks, the physician can and will go to work—provided that the price is right.*

For the second ethical school, morally neutral technique is morally used only when it is used under the guidance of general benevolence or loving charity. Not the will of the patient, but the humane and compassionate motive of the physician—not as physician but as human being—makes the doctor's actions ethical. Here, too, there can be strange requests and stranger deeds, but if they are done from love, nothing can be wrong—again, providing the law is silent. All acts—including killing the patient—done lovingly are licit, even praiseworthy. Good and humane intentions can sanctify any deed.

In my opinion, each of these approaches should be rejected as a basis for medical ethics. For one thing, neither can make sense of some specific

*Of course, any physician with personal scruples against one or another of these practices may "write" the relevant exclusions into the service contract he or she offers the customers.

duties and restraints long thought absolutely violate under the traditional medical ethic—for example, the proscription against having sex with patients. Must we now say that sex with patients is permissible if the patient wants it and the price is right, or, alternatively, if the doctor is gentle and loving and has a good bedside manner? Or do we glimpse in this absolute prohibition a deeper understanding of the medical vocation, which the prohibition both embodies and protects? Indeed, as I will now try to show, using the taboo against doctors killing patients, the medical profession has its own intrinsic ethic, which a physician true to his calling will not violate, either for love or for money.

II.

PROFESSION: INTRINSICALLY ETHICAL

Let me propose a different way of thinking about medicine as a profession. Consider medicine not as a mixed marriage between its own value-neutral technique and some extrinsic moral principles, but as an inherently ethical activity, in which technique and conduct are both ordered in relation to an overarching good, the naturally given end of health. This once traditional view of medicine I have defended at length.² Here I will present the conclusions without the arguments. It will suffice, for present purposes, if I can render this view plausible.

A profession, as etymology suggests, is an activity or occupation to which its practitioner publicly professes—that is, confesses—his devotion. Learning may, of course, be required of, and prestige may, of course, be granted to, the professional, but it is the profession's goal that calls, that learning serves, and that prestige honors. Each of the ways of life to which the various professionals profess their devotion must be a

way of life worthy of such devotion—and so they all are. The teacher devotes himself to assisting the learning of the young, looking up to truth and wisdom; the lawyer (or the judge) devotes himself to rectifying injustice for his client (or for the parties before the court), looking up to what is lawful and right; the clergyman devotes himself to tending the souls of his parishioners, looking up to the sacred and the divine; and the physician devotes himself to healing the sick, looking up to health and wholeness.

Being a professional is thus more than being a technician. It is rooted in our moral nature; it is a matter not only of the mind and hand but also of the heart, not only of intellect and skill but also of character. For it is only as a being willing and able to devote himself to others and to serve some high good that a person makes a public profession of his way of life.

The good to which the medical profession is devoted is health, a naturally given although precarious standard or norm, characterized by "wholeness" and "well-working," toward which the living body moves on its own. Even the modern physician, despite his great technological prowess, is but an assistant to natural powers of self-healing. But health, though a goal tacitly sought and explicitly desired, is difficult to attain and preserve. It can be ours only provisionally and temporarily, for we are finite and frail. Medicine thus finds itself in between: the physician is called to serve the high and universal goal of health while also ministering to the needs and relieving the sufferings of the frail and particular patient. Moreover, the physician must respond not only to illness but also to its meaning for each individual, who, in addition to his symptoms, may suffer from self-concern—and often fear and shame—about weakness and vulnerability, neediness and dependence, loss of self-esteem, and the fragility of all that matters to him. Thus, the inner meaning of the art of medicine is derived from the pursuit of health and the care for the ill and suffering, guided by the self-conscious awareness, shared (even if only tacitly) by physician and patient alike, of the delicate and dia-

lectual tension between wholeness and necessary decay.

When the activity of healing the sick is thus understood, we can discern certain virtues requisite for practicing medicine—among them, moderation and self-restraint, gravity, patience, sympathy, discretion, and prudence. We can also discern specific positive duties, addressed mainly to the patient's vulnerability and self-concern—including the demands for truthfulness, patient instruction, and encouragement. And, arguably, we can infer the importance of certain negative duties, formulable as absolute and unexceptionable rules. Among these, I submit, is this rule: *Doctors must not kill*. The rest of this article attempts to defend this rule and to show its relation to the medical ethic, itself understood as growing out of the inner meaning of the medical vocation.

I confine my discussion solely to the question of direct, intentional killing of patients by physicians—so-called mercy killing. Though I confess myself opposed to such killing even by nonphysicians,³ I am not arguing here against euthanasia per se. More importantly, I am not arguing against the cessation of medical treatment when such treatment merely prolongs painful or degraded dying, nor do I oppose the use of certain measures to relieve suffering that have, as an unavoidable consequence, an increased risk of death. Doctors may and must allow to die, even if they must not intentionally kill.

III.

BAD CONSEQUENCES

Although the bulk of my argument will turn on my understanding of the special meaning of professing the art of healing, I begin with a more familiar mode of ethical analysis: assessing needs and benefits versus dangers and harms. Still the best discussion of this topic is a now-classic essay by Yale Kamisar, written more than 30 years ago.⁴ Kamisar makes vivid the

difficulties in assuring that the choice for death will be freely made and adequately informed, the problems of physician error and abuse, the troubles for human relationships within families and between doctors and patients, the difficulty of preserving the boundary between voluntary and involuntary euthanasia, and the risks to the whole social order from weakening the absolute prohibition against taking innocent life. These considerations are, in my view, alone sufficient to rebut any attempt to weaken the taboo against medical killing; their relative importance for determining public policy far exceeds their relative importance in this essay. But here they serve also to point us to more profound reasons why doctors must not kill.

There is no question that fortune deals many people a very bad hand, not least at the end of life. All of us, I am sure, know or have known individuals whose last weeks, months, or even years were racked with pain and discomfort, degraded by dependency or loss of self-control, or who lived in such reduced humanity that it cast a deep shadow over their entire lives, especially as remembered by the survivors. All who love them would wish to spare them such an end, and there is no doubt that an earlier death could do it. Against such a clear benefit, attested to by many a poignant and heartrending true story, it is difficult to argue, especially when the arguments are necessarily general and seemingly abstract. Still, in the aggregate, the adverse consequences—including real suffering—of being governed solely by mercy and compassion may far outweigh the aggregate benefits of relieving agonal or terminal distress.

The first difficulty emerges when we try to gauge the so-called need or demand for medically assisted killing. This question, to be sure, is in part empirical. But evidence can be gathered only if the relevant categories of "euthanizable" people are clearly defined. Such definition is notoriously hard to accomplish—and it is not always honestly attempted. On careful inspection, we discover that if the category is precisely defined, the need for mercy killing seems greatly

exaggerated, and if the category is loosely defined, the poisoners will be working overtime.

The category always mentioned first to justify mercy killing is the group of persons suffering from incurable and fatal illnesses, with intractable pain and with little time left to live but still fully aware, who freely request a release from their distress—for example, people rapidly dying from disseminated cancer with bony metastases, unresponsive to chemotherapy. But as experts in pain control tell us, the number of such people with truly untreatable pain is in fact rather low. Adequate analgesia is apparently possible in the vast majority of cases, provided that the physician and patient are willing to use strong enough medicines in adequate doses and with proper timing.*

But, it will be pointed out, full analgesia induces drowsiness and blunts or distorts awareness. How can that be a desired outcome of treatment? Fair enough. But then the rationale for requesting death begins to shift from relieving experienced suffering to ending a life no longer valued by its bearer or, let us be frank, by the onlookers. If this becomes a sufficient basis to warrant mercy killing, the category of euthanizable people cannot be limited to individuals with incurable or fatal painful illnesses with little time to live. Now persons in all sorts of greatly reduced conditions—from persistent vegetative state to quadriplegia, from severe depression to the condition that now most horrifies, Alzheimer's disease—might have equal claim to have their suffering mercifully halted. The trouble, of course, is that most of these people can no longer request for themselves the dose of poison. Moreover, it will be difficult—if not impossible—to develop the requisite calculus of degradation or to define the threshold necessary for ending life.

In view of the obvious difficulty in describing precisely and "objectively" what categories and

degrees of pain, suffering, or bodily or mental impairment could justify mercy killing, advocates repair (at least for the time being) to the principle of volition: the request for assistance in death is to be honored because it is freely made by the one whose life it is, and who, for one reason or another, cannot commit suicide alone. But this too is fraught with difficulty: How free or informed is a choice made under debilitated conditions? Can consent long in advance be sufficiently informed about all the particular circumstances that it is meant prospectively to cover? And, in any case, are not such choices easily and subtly manipulated, especially in the vulnerable? Kamisar is very perceptive on this subject:

Is this the kind of choice. . . that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel that they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act? Will not some feel an obligation to have themselves 'eliminated' in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?⁴

Even were these problems soluble, the insistence on voluntariness as the justifying principle cannot be sustained. The enactment of a law—like the proposed Washington initiative—legalizing mercy killing on voluntary request will certainly be challenged in the courts under the equal protection clause of the Fourteenth Amendment. The law, after all, will not legalize assistance to suicides in general, but only mercy killing. The change will almost certainly occur not as an exception to the criminal law proscribing homicide, but as a new "treatment option," as part of a right to "a humane and dignified death." Why, it will be argued, should the comatose or the demented be denied such a right or such a "treatment" just because they cannot claim it for themselves? This line of reasoning has already been the route by which substituted judgment

*The inexplicable failure of many physicians to provide the proper and available relief of pain is surely part of the reason why some people now insist that physicians (instead) should give them death.

and proxy consent have been allowed by the courts in termination of treatment cases. When proxies give their consent, they will do so on the basis not of autonomy but of a substantive judgment—namely, that for these or those reasons, the life in question is not worth living.

Precisely because most of the cases that are candidates for mercy killing are of this sort, the line between voluntary and involuntary euthanasia cannot hold, and will be effaced by the intermediate case of the mentally impaired or comatose who are declared no longer willing to live because someone else wills that result for them. In fact, the more honest advocates of euthanasia openly admit that it is these non-voluntary cases which they especially hope to dispatch, and that their plea for *voluntary* euthanasia is just a first step. It is easy to see the trains of abuses that are likely to follow the most innocent cases, especially because the innocent cases cannot be precisely and neatly defined away from the rest.*

Abuses aside, legalized mercy killing by doctors will almost certainly damage the doctor-patient relationship. The patient's trust in the

doctor's whole-hearted devotion to the patient's best interests will be hard to sustain once doctors are licensed to kill. Imagine the scene: you are old, poor, in failing health, and alone in the world; you are brought to the city hospital with fractured ribs and pneumonia. The nurse or intern enters late at night with a syringe full of yellow stuff for your intravenous drip. How soundly will you sleep? It will not matter that your doctor has never yet put anyone to death; that he is legally entitled to do so will make a world of difference.

And it will make a world of psychic difference too for conscientious physicians. How easily will they be able to care whole-heartedly for patients when it is always possible to think of killing them as a "therapeutic option"? Shall it be penicillin and a respirator one more time, or, perhaps, this time just an overdose of morphine? Physicians get tired of treating patients who are hard to cure, who resist their best efforts, who are on their way down—"gorks," "gomers," and "vegetables" are only some of the less than affectionate names they receive from the house officers. Won't it be tempting to think that death is the best "treatment" for the little old lady "dumped" again on the emergency room by the nearby nursing home?

Even the most humane and conscientious physician psychologically needs protection against himself and his weaknesses, if he is to care fully for those who entrust themselves to him. A physician-friend who worked many years in a hospice caring for dying patients explained it to me most convincingly: "Only because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying." The psychological burden of the license to kill (not to speak of the brutalization of the physician-killers) could very well be an intolerably high price to pay for physician-assisted euthanasia.

The point, however, is not merely psychological: it is also moral and essential. My friend's horror at the thought that he might be tempted to kill his patients, were he not enjoined from

*This is no mere scare-mongering. Recent reports on the practice of euthanasia in Holland provide ample proof. In a study of 300 physicians, published in 1989, Professor F.C.B. van Wijnen (a supporter of euthanasia) found that more than 40 percent admitted to having performed *involuntary* euthanasia at least once, and more than 10 percent five times or more.

The Dutch Government's Report (September 1991), despite its reassuring conclusions, provides even more alarming data: in addition to 2,300 cases (per year) of voluntary euthanasia and 400 cases of physician-assisted suicide, there were over 1,000 cases of active *involuntary* euthanasia, without the patients' knowledge or consent, including over 100 cases in which the patients were mentally competent. In addition, of 8,100 cases in which overdoses of morphine were given with the intent to terminate life, 61 percent were without patient knowledge or consent. "Low quality of life," "the family couldn't take it any more," and "little hope of improvement" were reasons that physicians gave for killing patients without request.

Finally, an excellent book, *Regulating Death: Euthanasia and the Case of the Netherlands*, by Carlos Gomez, MD, shows how the Dutch practice departs extensively from the guidelines set down by the Dutch Medical Society, and makes clear why the practice of euthanasia is, necessarily, virtually unregulable.

doing so, embodies a deep understanding of the medical ethic and its intrinsic limits. We move from assessing consequences to looking at medicine itself.

IV. MEDICINE'S OUTER LIMITS

Every activity can be distinguished, more or less easily, from other activities. Sometimes the boundaries are indistinct: it is not always easy, especially today, to distinguish some music from noise or art from smut or some teaching from indoctrination. Medicine and healing are no different: it is sometimes hard to determine the boundaries, both with regard to ends and means. Is all cosmetic surgery healing? Are placebos—or food and water—drugs?

There is, of course, a temptation to finesse these questions of definition or to deny the existence of boundaries altogether: medicine *is* whatever doctors *do*, and doctors do whatever doctors can. Technique and power alone define the art. Put this way, we see the need for limits: Technique and power are ethically neutral, notoriously so, usable for both good and ill. The need for finding or setting limits to the use of powers is especially important when the powers are dangerous: it matters more that we know the proper limits on the use of medical power—or military power—than, say, the proper limits on the use of paint brush or violin.

The beginning of ethics regarding the use of power generally lies in nay-saying. The wise setting of limits on the use of power is based on discerning the excesses to which the power, unrestrained, is prone. Applied to the professions, this principle would establish strict outer boundaries—indeed, inviolable taboos—against those “occupational hazards” to which each profession is especially prone. Within these outer limits, no fixed rules of conduct apply; instead, prudence—the wise judgment of the man-on-the-spot—finds

and adopts the best course of action in the light of the circumstances. But the outer limits themselves are fixed, firm, and nonnegotiable.

What are those limits for medicine? At least three are set forth in the venerable Hippocratic Oath: no breach of confidentiality, no sexual relations with patients, and no dispensing of deadly drugs.* These unqualified, self-imposed restrictions are readily understood in terms of the temptations to which the physician is most vulnerable, temptations in each case regarding an area of vulnerability and exposure that the practice of medicine requires of patients. Patients necessarily divulge and reveal private and intimate details of their personal lives; patients necessarily expose their naked bodies to the physician's objectifying gaze and investigating hands; patients necessarily expose and entrust the care of their very lives to the physician's skill, technique, and judgment. The exposure is, in all cases, one-sided and asymmetric: the doctor does not reveal his intimacies, display his nakedness, offer up his embodied life to the patient. Mindful of the meaning of such nonmutual exposure, the physician voluntarily sets limits on his own conduct, pledging not to take advantage of or to violate the patient's intimacies, naked sexuality, or life itself.

The prohibition against killing patients, the first negative promise of self-restraint sworn to in the Hippocratic Oath, stands as medicine's first and most-abiding taboo: “I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. . . In purity and holiness I will guard my life and my art.” In forswearing the giving of poison, the physician recognizes and restrains a god-like power he wields over patients, mindful that his drugs can both cure and kill. But in forswearing the giving of poison, *when asked for it*, the Hippocratic physician rejects the view that the patient's choice for death can make killing him, or assisting his

*See, in Reference #2, my essay on the Hippocratic Oath, especially pages 232–240. See also the chapter, “Professing Ethically: The Place of Ethics in Defining Medicine,” especially pages 217–223.

suicide, right. For the physician, at least, human life in living bodies commands respect and reverence, by its very nature. As its respectability does not depend upon human agreement or patient consent, revocation of one's consent to live does not deprive one's living body of respectability. The deepest ethical principle restraining the physician's power is not the autonomy or freedom of the patient; neither is it his own compassion or good intention. Rather, it is the dignity and mysterious power of human life itself, and, therefore, also what the Oath calls the purity and holiness of the life and art to which he has sworn devotion. A person can choose to be a physician, but he cannot simply choose what physicianship means.

V.

THE CENTRAL CORE

The central meaning of physicianship derives not from medicine's powers but from its goal, not from its means but from its end: to benefit the sick by the activity of healing. The physician as physician serves only the sick. He does not serve the relatives or the hospital or the national debt inflated due to Medicare costs. Thus he will never sacrifice the well-being of the sick to the convenience or pocketbook or feelings of the relatives or society. Moreover, the physician serves the sick not because they have rights or wants or claims, but because they are sick. The healer works with and for those who need to be healed, in order to help make them whole.

Despite enormous changes in medical technique and institutional practice, despite enormous changes in nosology and therapeutics, the center of medicine has not changed: it is as true today as it was in the days of Hippocrates that the ill desire to be whole; that wholeness means a certain well-working of the enlivened body and its unimpaired powers to sense, think, feel, desire, move, and maintain itself; and that the relationship between the healer and the ill is constituted, essentially even if only tacitly, around

the desire of both to promote the wholeness of the one who is ailing.

The wholeness and well-working of a human being is, of course, a rather complicated matter, much more so than for our animal friends and relations. Health and fitness seem to mean different things to different people, or even to the same person at different times of life. Yet not everything is relative and contextual; beneath the variable and cultural lies the constant and organic, the well-regulated, properly balanced, and fully empowered human being. Indeed, only the existence of this natural and universal subject makes possible the study of medicine.

But human wholeness goes beyond the kind of somatic wholeness abstractly and reductively studied by the modern medical sciences. Whether or not doctors are sufficiently prepared by their training to recognize it, those who seek medical help in search of wholeness are not to *themselves* just bodies or organic machines. Each person intuitively knows himself to be a center of thoughts and desires, deeds and speeches, loves and hates, pleasures and pains, but a center whose workings are none other than the workings of his enlivened and mindful body. The patient presents himself to the physician, tacitly to be sure, as a psychophysical unity, as a *one*, not just a body, but also not just as a separate disembodied person that simply *has* or *owns* a body. The person and the body are self-identical. True, sickness may be experienced largely as belonging to the body as something other; but the healing one wants is the wholeness of one's entire embodied being. Not the wholeness of *soma*, not the wholeness of *psyche*, but the wholeness of *anthropos* as a (puzzling) concretion of *soma-psyche* is the benefit sought by the sick. This human wholeness is what medicine is finally all about.

Can wholeness and healing, thus understood, ever be compatible with intentionally killing the patient? Can one benefit the patient as a whole by making him dead? There is, of course, a logical difficulty: how can any good exist for a being that is not? "Better off dead" is logical nonsense—unless, of course, death is not death in-

deed but instead a gateway to a new and better life beyond. But the error is more than logical: in fact, to intend and to act for someone's good requires their continued existence to receive the benefit.

To be sure, certain attempts to benefit may in fact turn out, unintentionally, to be lethal. Giving adequate morphine to control pain might induce respiratory depression leading to death. But the intent to relieve the pain of the living presupposes that the living still live to be relieved. This must be the starting point in discussing all medical benefits: no benefit without a beneficiary.

Against this view, someone will surely bring forth the hard cases: patients so ill-served by their bodies that they can no longer bear to live, bodies riddled with cancer and racked with pain, against which their "owners" protest in horror and from which they insist on being released. Cannot the person "in the body" speak up against the rest, and request death for "personal" reasons?

However sympathetically we listen to such requests, we must see them as incoherent. Such person-body dualism cannot be sustained. "Personhood" is manifest on earth only in living bodies; our highest mental functions are held up by, and are inseparable from, lowly metabolism, respiration, circulation, excretion. There may be blood without consciousness, but there is never consciousness without blood. Thus, one who calls for death in the service of personhood is like a tree seeking to cut its roots for the sake of growing its highest fruit. No physician, devoted to the benefit of the sick, can serve the patient as person by denying and thwarting his personal embodiment. The boundary condition, "no deadly drugs," flows directly from the center, "make whole."

To say it plainly, to bring nothingness is incompatible with serving wholeness: one cannot heal, or comfort, by making nil. The healer cannot annihilate if he is truly to be a healer. The physician-euthanizer is a deadly self-contradiction.

VI. WHEN MEDICINE FAILS

But we must acknowledge a difficulty. The central goal of medicine—health—is, in each case, a perishable good: inevitably, patients get irreversibly sick, patients degenerate, patients die. Healing the sick is in principle a project that must at some point fail. And here is where all the trouble begins: How does one deal with "medical failure"? What does one seek when restoration of wholeness—or "much" wholeness—is by and large out of the question?

Contrary to the propaganda of the euthanasia movement, there is, in fact, much that can be done. Indeed, by recognizing finitude yet knowing that we will not kill, we are empowered to focus on easing and enhancing the lives of those who are dying. First of all, medicine can follow the lead of the hospice movement and, abandoning decades of shameful mismanagement, provide truly adequate (and now technically feasible) relief of pain and discomfort. Second, physicians (and patients and families) can continue to learn how to withhold or withdraw those technical interventions that are, in truth, merely burdensome or degrading medical additions to the unhappy end of a life—including, frequently, hospitalization itself. Ceasing treating and allowing death to occur when (and if) it will seem to be quite compatible with the respect life itself commands for itself. For life can be revered not only in its preservation, but also in the manner in which we allow a given life to reach its terminus. To repeat: doctors may and must allow to die, even if they must not intentionally kill.

Ceasing medical intervention, allowing nature to take its course, differs fundamentally from mercy killing. For one thing, death does not necessarily follow the discontinuance of treatment. Karen Ann Quinlan lived roughly 10 years after the court allowed the "life-sustaining" respirator to be removed. Not the physician, but the underlying fatal illness becomes the true cause of death. More important morally, in ceasing treat-

ment the physician need not *intend* the death of the patient, even when the death follows as a result of his omission. His intention should be to avoid useless and degrading medical *additions* to the already sad end of a life. In contrast, in active, direct mercy killing the physician must, necessarily and indubitably, intend *primarily* that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death. This remains true even if he is merely an assistant in suicide. A physician who provides the pills or lets the patient plunge the syringe after he leaves the room is morally no different from one who does the deed himself. "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect."

VII. BEING HUMANE AND BEING HUMAN

Once we refuse the technical fix, physicians and the rest of us can also rise to the occasion: we can learn to act humanly in the presence of finitude. Far more than adequate morphine and the removal of burdensome chemotherapy, the dying need our presence and our encouragement. Dying people are all too easily reduced ahead of time to "thinghood" by those who cannot bear to deal with the suffering or disability of those they love. Withdrawal of contact, affection, and care is the greatest single cause of the dehumanization of dying. Not the alleged humaneness of an elixir of death, but the humanness of connected living-while-dying is what medicine, and the rest of us, most owes the dying. The treatment of choice is company and care.

The euthanasia movement would have us believe that the physician's refusal to assist in suicide or perform euthanasia constitutes an affront to human dignity. Yet one of their favorite argu-

ments seems to me rather to prove the reverse. Why, it is argued, do we put animals out of their misery but insist on compelling fellow human beings to suffer to the bitter end? Why, if it is not a contradiction for the veterinarian, does the medical ethic absolutely rule out mercy killing? Is this not simply inhumane?

Perhaps inhumane, but not thereby inhuman. On the contrary, it is precisely because animals are not human that we must treat them (merely) humanely. We put dumb animals to sleep because they do not know that they are dying, because they can make nothing of their misery or mortality, and, therefore, because they cannot live deliberately (humanly) in the face of their own suffering or dying. They cannot live out a fitting end. Compassion for their weakness and dumbness is our only appropriate emotion, and given our responsibility for their care and well-being, we do the only humane thing we can.

But when a conscious human being asks us for death, by that very action he displays the presence of something that precludes our regarding him as a dumb animal. Humanity is owed humanity, not humaneness. Humanity is owed the bolstering of the human, even or especially in its dying moments, in resistance to the temptation to ignore its presence in the sight of suffering.

What humanity needs most in the face of evils is courage, the ability to stand against fear and pain and thoughts of nothingness. The deaths we most admire are those of people who, knowing that they are dying, face the fact frontally and act accordingly: they set their affairs in order, they arrange what could be final meetings with their loved ones, and yet, with strength of soul and a small reservoir of hope, they continue to live and work and love as much as they can for as long as they can. Because such conclusions of life require courage, they call for our encouragement, and for the many small speeches and deeds that shore up the human spirit against despair and defeat.

Many doctors are in fact rather poor at this sort of encouragement. They tend to regard every dying or incurable patient as a failure, as if an

earlier diagnosis or a more vigorous intervention might have avoided what is, in truth, an inevitable collapse. The enormous successes of medicine these past 50 years have made both doctors and laymen less prepared than ever to accept the fact of finitude. Physicians today are not likely to be agents of encouragement once their technique begins to fail.

It is, of course, partly for these reasons that doctors will be pressed to kill—and many of them will, alas, be willing. Having adopted a largely technical approach to healing, having medicalized so much of the end of life, doctors are being asked, often with thinly veiled anger, to provide a technical final solution for the evil of human finitude and for their own technical failure: If you cannot cure me, kill me. The last gasp of autonomy or cry for dignity is asserted against a medicalization and institutionalization of the end of life that robs the old and the incurable of most of their autonomy and dignity: intubated and electrified, with bizarre mechanical companions, once proud and independent people find themselves cast in the roles of passive, obedient, highly disciplined children. People who care for autonomy and dignity should try to reverse this dehumanization of the last stages of life, instead of giving dehumanization its final triumph by welcoming the desperate goodbye-to-all-that contained in one final plea for poison.

The present crisis that leads some to press for active euthanasia is really an opportunity to learn the limits of the medicalization of life and death and to recover an appreciation of living with and against mortality. It is an opportunity for physicians to recover an understanding that there remains a residual human wholeness, however precarious, that can be cared for even in the face of incurable and terminal illness. Should doctors cave in, should doctors become technical dispensers of death, they will not only be abandoning their posts, their patients, and their duty to care; they will set the worst sort of example for the community at large—teaching technicism and so-called humaneness where encouragement and humanity are both required and sorely lack-

ing. On the other hand, should physicians hold fast, should doctors learn that finitude is no disgrace and that human wholeness can be cared for to the very end, medicine may serve not only the good of its patients, but also, by example, the failing moral health of modern times. □

References

1. "It's over, Debbie." *JAMA*, 259:272, 1988. In response, see also Gaylin W, Kass LR, Pellegrino ED, and Siegler M: Doctors must not kill. *JAMA*, 259: 2139–2140, 1988.
2. Kass LR: *Toward a More Natural Science: Biology and Human Affairs*. New York: The Free Press, 1985; paperback, 1988. (See, especially, chapters 6–9.)
3. Kass LR: Death with dignity and the sanctity of life. *Commentary*, March, 1990.
4. Kamisar Y: Some nonreligious views against proposed "mercy killing" legislation. *Minn Law Rev*, 42:969–1042, 1958. [Reprinted, with a new preface by Kamisar, in "The Slide Toward Mercy Killing," *Child and Family Reprint Booklet Series*, 1987.]

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I has been fashionable for some time now and in many aspects of American public life for people to demand what they want or need as a matter of rights. During the past few decades we have heard claims of a right to health or health care, a right to education or employment, a right to privacy (embracing also a right to abort or to enjoy pornography, or to commit suicide or sodomy), a right to clean air, a right to dance naked, a right to be born, and a right not to have been born. Most recently we have been presented with the ultimate new rights claim, a "right to die."

This claim has surfaced in the context of changed circumstances and burgeoning concerns regarding the end of life. Thanks in part to the power of medicine to preserve and prolong life, many of us are fated to end our once-flourishing lives in years of debility, dependence, and disgrace. Thanks to the respirator and other powerful technologies that can, all by themselves, hold comatose and other severely debilitated patients on this side of the line between life and death, many who would be dead are alive only because of sustained mechanical intervention. Of the 2.2 million annual deaths in the United States, 80 percent occur in health care facilities; in roughly 1.5 million of these cases, death is preceded by some explicit decision about stopping or not starting medical treatment. Thus, death in America is not only medically managed, but its timing is also increasingly subject to deliberate choice. It is from this background that the claims of a right to die emerge.

I do not think that the language and approach of rights are well suited either to sound personal decision-making or to sensible public policy in this very difficult and troubling matter. In most of the heartrending end-

of-life situations, it is hard enough for practical wisdom to try to figure out what is morally right and humanly good, without having to contend with intransigent and absolute demands of a legal or moral right to die. And, on both philosophical and legal grounds, I am inclined to believe that there can be no such thing as a *right* to die—that the notion is groundless and perhaps even logically incoherent. Even its proponents usually put "right to die" in quotation marks, acknowledging that it is at best a misnomer.

Nevertheless, we cannot simply dismiss this claim, for it raises important and interesting practical and philosophical questions. Practically, a right to die is increasingly asserted and gaining popular strength; increasingly, we see it in print without the quotation marks. The former Euthanasia Society of America, shedding the Nazi-tainted and easily criticized "E" word, changed its name to the more politically correct Society for the Right to Die before becoming Choice In Dying. End-of-life cases coming before the courts, nearly always making their arguments in terms of rights, have gained support for some sort of "right to die." The one case to be decided by a conservative Supreme Court, the *Cruzan* case, has advanced the cause, as I will show.

The voter initiatives to legalize physician-assisted suicide and euthanasia in Washington and California were narrowly defeated, in part be-

cause they were badly drafted laws; yet the proponents of such practices seem to be winning the larger social battle over principle. According to several public opinion polls, most Americans now believe that "if life is miserable, one has the right to get out, actively and with help if necessary." Though the burden of philosophical proof for establishing new rights (especially one as bizarre as a "right to die") should always fall on the proponents, the social burden of proof has shifted to those who would oppose the voluntary choice of death through assisted suicide. Thus it has become politically necessary—and at the same time exceedingly difficult—to make principled arguments about why doctors must not kill, about why euthanasia is not the proper human response to human finitude, and about why there is no right to die, natural or constitutional. This is not a merely academic matter: our society's willingness and ability to protect vulnerable life hang in the balance.

An examination of "right to die" is even more interesting philosophically. It reveals the dangers and the limits of the liberal—that is, rights-based—political philosophy and jurisprudence to which we Americans are wedded. As the ultimate new right, grounded neither in nature nor in reason, it demonstrates the nihilistic implication of a new ("postliberal") doctrine of rights, rooted in the self-creating will. And as liberal society's response to the bittersweet victories

Is There a Right to Die?

by Leon R. Kass

To speak of rights in the very troubling matter of medically managed death is ill suited both to sound personal decision-making and to sensible public policy. There is no firm philosophical or legal argument for a "right to die."

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of the medical project to conquer death, it reveals in pure form the tragic meaning of the entire modern project, both scientific and political.

The claim of a right to die is made only in Western liberal societies—not surprisingly, for only in Western liberal societies do human beings look first to the rights of individuals. Also, only here do we find the high-tech medicine capable of keeping people from dying when they might wish. Yet the claim of a right to die is also a profoundly strange claim, especially in a liberal society founded on the primacy of the right to life. We Americans hold as a self-evident truth that governments exist to secure inalienable rights, first of all, to self-preservation; now we are being encouraged to use government to secure a putative right of self-destruction. A "right to die" is surely strange and unprecedented, and hardly innocent. Accordingly, we need to consider carefully what it could possibly mean, why it is being asserted, and whether it really exists—that is, whether it can be given a principled grounding or defense.

A Right to Die

Though the major ambiguity concerns the substance of the right—namely, to die—we begin by reminding ourselves of what it means, in general, to say that someone has a right to something. I depart for now from the original notion of *natural* rights, and indeed abstract altogether from the question of the source of rights. I focus instead on our contemporary usage, for it is only in contemporary usage that this current claim of a right to die can be understood.

A right, whether legal or moral, is not identical to a need or a desire or an interest or a capacity. I may have both a need and a desire for, and also an interest in, the possessions of another, and the capacity or power to take them by force or stealth—yet I can hardly be said to have a right to them. A right, to begin with, is a species of liberty. Thomas Hobbes, the first teacher of rights, held a right to be a *blameless* liberty. Not everything we are free to do, morally or legally, do we have a right to do: I may be at liberty to wear offensive perfumes or to sass my parents or to engage in

unnatural sex, but it does not follow that I have a right to do so. Even the decriminalization of a once-forbidden act does not yet establish a legal right, not even if I can give reasons for doing it. Thus, the freedom to take my life—"I have inclination, means, reasons, opportunity, and you cannot stop me, and it is not against the law"—does not suffice to establish the right to take my life. A true right would be at least a blameless or permitted liberty, at best a praiseworthy or even rightful liberty, to do or not to do, without anyone else's interference or opposition.

Historically, the likelihood of outside interference and opposition was in fact the necessary condition for the assertion of rights. Rights were and are, to begin with, *political* creatures, the first principles of liberal politics. The rhetoric of claiming rights, which are in principle always absolute and unconditional, performs an important function of defense, but only because the sphere of life in which they are asserted is limited. Rights are asserted to protect, by deeming them blameless or rightful, certain liberties that others are denying or threatening to curtail. Rights are claimed to defend the safety and dignity of the individual against the dominion of tyrant, king, or prelate, and against those high-minded moralizers and zealous meddlers who seek to save man's soul or to preserve his honor at the cost of his life and liberty.

To these more classical, negative rights against interference with our liberties, modern thought has sought to add certain so-called welfare rights—rights that entitle us to certain opportunities or goods to which, it is argued, we have a rightful claim on others, usually government, to provide. The rhetoric of welfare rights extends the power of absolute and unqualified claims beyond the goals of defense against tyranny and beyond the limited sphere of endangered liberties; for these reasons their legitimacy as rights is often questioned. Yet even these ever-expanding lists of rights are not unlimited. I cannot be said to have a right to be loved by those whom I hope will love me, or a right to become wise. There are many good things that I may rightfully possess and enjoy, but to which

I have no claim if they are lacking. Most generally, then, having a right means having a *justified* claim against others that they act in a fitting manner: either that they refrain from interfering or that they deliver what is justly owed. It goes without saying that the mere assertion of a claim or demand, or the stipulation of a right, is insufficient to establish it; making a claim and actually having a rightful claim to make are not identical. In considering an alleged right to die, we must be careful to look for a *justifiable* liberty or claim, and not merely a desire, interest, power, or demand.

Rights seem to entail obligations: one person's right, whether to noninterference or to some entitled good or service, necessarily implies another person's obligation. It will be important later to consider what obligations on others might be entailed by enshrining a right to die.

A Right to Die

Taken literally, a right to die would denote merely a right to the inevitable; the certainty of death for all that lives is the touchstone of fated inevitability. Why claim a right to what is not only unavoidable, but is even, generally speaking, an evil? Is death in danger of losing its inevitability? Are we in danger of bodily immortality? Has death, for us, become a good to be claimed rather than an evil to be shunned or conquered?

Not exactly and not yet, though these questions posed by the literal reading of "right to die" are surely germane. They hint at our growing disenchantment with the biomedical project, which seeks, in principle, to prolong life indefinitely. It is the already available means to sustain life for prolonged periods—not indefinitely, but far longer than is in many cases reasonable or desirable—that has made death so untimely late as to seem less than inevitable, that has made death, when it finally does occur, appear to be a blessing.

For we now have medical "treatments" (that is, interventions) that do not treat (that is, cure or ameliorate) specific diseases, but do nothing more than keep people alive by sustaining vital functions. The most notorious

such device is the respirator. Others include simple yet still artificial devices for supplying food and water and the kidney dialysis machine for removing wastes. And, in the future, we shall have the artificial heart. These devices, backed by aggressive institutional policies favoring their use, are capable of keeping people alive, even when comatose, often for decades. The "right to die," in today's discourse, often refers to—and certainly is meant to embrace—a right to refuse such life-sustaining medical treatment.

But the "right to die" usually embraces also something more. The ambiguity of the term blurs over the difference in content and intention between the already well-established common-law right to refuse surgery or other unwanted medical treatments and hospitalization and the newly alleged "right to die." The former permits the refusal of therapy, even a respirator, even if it means accepting an increased risk of death. The latter permits the refusal of therapy, such as renal dialysis or the feeding tube, so that death will occur. The former seems more concerned with choosing how to live while dying; the latter seems mainly concerned with a choice for death. In this sense the claimed "right to die" is not a misnomer.

Still less is it a misnomer when we consider that some people who are claiming it demand not merely the discontinuance of treatment but positive assistance in bringing about their deaths. Here the right to die embraces the (welfare!) right to a lethal injection or an overdose of pills administered by oneself, by one's physician, or by someone else. This "right to die" would better be called a right to assisted suicide or a right to be mercifully killed—in short, a right to become dead, by assistance if necessary.

This, of course, looks a lot like a claim to a right to commit suicide, which need not have any connection to the problems of dying or medical technology. Some people in fact argue that the "right to die" through euthanasia or medically assisted suicide grows not from a right to refuse medical treatment but rather from this putative right to commit suicide (suicide is now decriminalized in

most states). There does seem to be a world of moral difference between submitting to death (when the time has come) and killing yourself (in or out of season), or between permitting to die and causing death. But the boundary becomes fuzzy with the alleged right to refuse food and water,

This analysis of current usage shows why one might be properly confused about the meaning of the term "right to die." In public discourse today, it merges all the aforementioned meanings: right to refuse treatment even if, or so that, death may occur; right to be killed or to

It is certainly proper to understand the "right to die" as a right to become or to be made dead, by whatever means.

artificially delivered. Though few proponents of a right to die want the taint of a general defense of suicide (which though decriminalized remains in bad odor), they in fact presuppose its permissibility and go well beyond it. They claim not only a right to attempt suicide but a right to succeed, and this means, in practice, a right to the deadly assistance of others. It is thus certainly proper to understand the "right to die" in its most radical sense, namely, as a right to become or to be made dead, by whatever means.

This way of putting the matter will not sit well with those who see the right to die less as a matter of life and death, more as a matter of autonomy or dignity. For them the right to die means the right to continue, despite disability, to exercise control over one's own destiny. It means, in one formulation, not the right to become dead, but the right to choose the manner, the timing, and the circumstances of one's death, or the right to choose what one regards as the most humane or dignified way to finish out one's life. Here the right to die means either the right to self-command or the right to death with dignity—claims that would oblige others, at a minimum, to stop interfering, but also, quite commonly, to "assist self-command" or to "provide dignity" by participating in bringing one's life to an end, according to plan. In the end, these proper and high-minded demands for autonomy and dignity turn out in most cases to embrace also a right to become dead, with assistance if necessary.

become dead; right to control one's own dying; right to die with dignity; right to assistance in death. Some of this confusion inheres in the term: some of it is deliberately fostered by proponents of all these "rights," who hope thereby to gain assent to the more extreme claims by merging them with the more modest ones. Partly for this reason, however, we do well to regard the "right to die" at its most radical—and I will do so in this essay—as a right to become dead, by active means and if necessary with the assistance of others. In this way we take seriously and do justice to the novelty and boldness of the claim, a claim that intends to go beyond both the existing common-law right to refuse unwanted medical treatment and the so-called right to commit suicide all by oneself. (The first right is indisputable, the second, while debatable, will not be contested in this essay. What concerns us here is those aspects of the "right to die" that go beyond a right to attempt suicide and a right to refuse treatment.)

Having sought to clarify the meaning of "right to die," we face next the even greater confusion about who it is that allegedly has such a right. Is it only those who are "certifiably" terminally ill and irreversibly dying, with or without medical treatment? Also those who are incurably ill and severely incapacitated, although definitely not dying? Everyone, mentally competent or not? Does a senile person have a "right to die" if he is incapable of claiming it for himself? Do I need to be able to claim and act on such a right in order to have it, or

can proxies be designated to exercise my right to die on my behalf? If the right to die is essentially an expression of my autonomy, how can anyone else exercise it for me?

Equally puzzling is the question, Against whom or what is a right to die being asserted? Is it a liberty right mainly against those officious meddlers who keep me from dying—against those doctors, nurses, hospitals, right-to-life groups, and district attorneys who interfere either with my ability to die (by machinery and hospitalization) or with my ability to gain help in ending my life (by criminal sanctions against assisting suicide)? If it is a right to become dead, is it not also a welfare right claimed against those who do not yet assist—a right demanding also the provision of the poison that I have permission to take? (Compare the liberty right to seek an abortion with the welfare right to obtain one.) Or is it, at bottom, a demand asserted also *against nature*, which has dealt me a bad hand by keeping me alive, beyond my wishes and beneath my dignity, and alas without terminal illness, too senile or enfeebled to make matters right?

The most radical formulations, whether in the form of "a right to become dead" or "a right to control my destiny" or "a right to dignity," are, I am convinced, the complaint of human pride against what our tyrannical tendencies lead us to experience as "cosmic injustice, directed against me." Here the ill-fated demand a right not to be ill-fated; those who want to die, but cannot, claim a right to die, which becomes, as Harvey Mansfield has put it, a tort claim against nature. It thus becomes the business of the well-fated to correct nature's mistreatment of the ill-fated *by making them dead*. Thus would the same act that was only yesterday declared a crime against humanity become a mandated act, not only of compassionate charity but of compensatory justice!

Why Assert a Right to Die?

Before proceeding to the more challenging question of the existence and ground of a "right to die," it would be useful briefly to consider why such a right is being asserted,

and by whom. Some of the reasons have already been noted in passing:

- fear of prolongation of dying due to medical intervention; hence, a right to refuse treatment or hospitalization, even if death occurs as a result;
- fear of living too long, without fatal illness to carry one off; hence, a right to assisted suicide;
- fear of the degradations of senility and dependence; hence, a right to death with dignity;
- fear of loss of control; hence, a right to choose the time and manner of one's death.

Equally important for many people is the fear of becoming a burden to others—financial, psychic, social. Few parents, however eager or willing they might be to stay alive, are pleased by the prospect that they might thereby destroy their children's and grandchildren's opportunities for happiness. Indeed, my own greatest weakening on the subject of euthanasia is precisely this: I would confess a strong temptation to remove myself from life to spare my children the anguish of years of attending my demented self and the horrible likelihood that they will come, hatefully to themselves, to resent my continued existence. Such reasons in favor of death might even lead me to think I had a *duty* to die—they do not, however, establish for me any right to become dead.¹

But the advocates of a "right to die" are not always so generous. On the contrary, much dishonesty and mischief are afoot. Many people have seen the advantage of using the language of individual rights, implying voluntary action, to shift the national attitudes regarding life and death, to prepare the way for the practice of terminating "useless" lives.²

Many who argue for a right to die mean for people not merely to have it but to exercise it with dispatch, so as to decrease the mounting socioeconomic costs of caring for the irreversibly ill and dying. In fact, most of the people now agitating for a "right to die" are themselves neither ill nor dying. Children looking at parents who are not dying fast enough, hospital administrators and health economists concerned about cost-cutting and waste, doctors disgusted

with caring for incurables, people with eugenic or aesthetic interests who are repelled by the prospect of a society in which the young and vigorous expend enormous energy to keep alive the virtually dead—all these want to change our hard-won ethic in favor of life.

But they are either too ashamed or too shrewd to state their true intentions. Much better to trumpet a right to die, and encourage people to exercise it. These advocates understand all too well that the present American climate requires one to talk of rights if one wishes to have one's way in such moral matters. Consider the analogous use of arguments for abortion rights by organizations which hope thereby to get women—especially the poor, the unmarried, and the nonwhite—to exercise their "right to choose," to do their supposed duty toward limiting population growth and the size of the underclass.

This is not to say that all reasons for promoting a "right to die" are suspect. Nor do I mean to suggest that it would never be right or good for someone to elect to die. But it might be dangerous folly to circumvent the grave need for prudence in these matters by substituting the confused yet absolutized principle of a "right to die," especially given the mixed motives and dangerous purposes of some of its proponents.

Truth to tell, public discourse about moral matters in the United States is much impoverished by our eagerness to transform questions of the right and the good into questions about individual rights. Partly, this is a legacy of modern liberalism, the political philosophy on which the genius of the American republic mainly rests. But it is augmented by American self-assertion and individualism, increasingly so in an age when family and other mediating institutions are in decline and the naked individual is left face to face with the bureaucratic state.

But the language of rights gained a tremendous boost from the moral absolutism of the 1960s, with the discovery that the nonnegotiable and absolutized character of all rights claims provides the most durable battering ram against the status quo. Never mind that it fuels resentments

and breeds hatreds, that it ignores the consequences to society, or that it short-circuits a political process that is more amenable to working out a balanced view of the common good. Never mind all that: go to court and demand your rights. And the courts have been all too willing to oblige, finding or inventing new rights in the process.

These sociocultural changes, having nothing to do with death and dying, surely are part of the reason we are now confronted with vociferous claims of a right to die. These changes are also part of the reason why, despite its notorious difficulties, a right to die is the leading moral concept advanced to address these most complicated and delicate human matters at the end of life. Yet the reasons for the assertion, even if suspect, do not settle the question of truth, to which, at long last, we finally turn. Let us examine whether philosophically or legally we can truly speak of a right to die.

Is There a Right to Die?

Philosophically speaking, it makes sense to take our bearings from those great thinkers of modernity who are the originators and most thoughtful exponents of our rights-based thinking. They above all are likely to have understood the purpose, character, grounds, and limits for the assertion of rights. If a newly asserted right, such as the right to die, cannot be established on the natural or rational ground for rights offered by these thinkers, the burden of proof must fall on the proponents of novel rights, to provide a new yet equally solid ground in support of their novel claims.

If we start at the beginning, with the great philosophical teachers of natural rights, the very notion of a right to die would be nonsensical. As we learn from Hobbes and from John Locke, all the rights of man, given by nature, presuppose our self-interested attachment to our own lives. All natural rights trace home to the primary right to life, or better, the right to self-preservation—itself rooted in the powerful, self-loving impulses and passions that seek our own continuance, and asserted first against

deadly, oppressive polities or against those who might insist that morality requires me to turn the other cheek when my life is threatened. Mansfield summarizes the classical position elegantly:

Rights are given to men by nature, but they are needed because men are also subject to nature's providence. Since life is in danger, men's equal rights would be to life, to the liberty that protects life, and to the pursuit of the happiness with which life, or a tenuous life, is occupied.

In practice, the pursuit of happiness will be the pursuit of property, for even though property is less valuable than life or liberty, it serves as guard for them. Quite apart from the pleasures of being rich, having secure property shows that one has liberty secure from invasion either by the government or by others; and secure liberty is the best sign of a secure life.³

Because death, my extinction, is the evil whose avoidance is the condition of the possibility of my having any and all of my goods, my right to secure my life against death—that is, my rightful liberty to self-preserved conduct—is the bedrock of all other rights and of all politically relevant morality. Even Hans Jonas, writing to defend "the right to die," acknowledges that it stands alone, and concedes that "every other right ever argued, claimed, granted, or denied can be viewed as an extension of this primary right [to life], since every particular right concerns the exercise of some faculty of life, the access to some necessity of life, the satisfaction of some aspiration of life."⁴ It is obvious that one cannot found on this rock any right to die or right to become dead. Life loves to live, and it needs all the help it can get.

This is not to say that these early modern thinkers were unaware that men might tire of life or might come to find existence burdensome. But the decline in the will to live did not for them drive out or nullify the right to life, much less lead to a trumping new right, a right to die. For the right to life is a matter of nature, not will.

Locke addresses and rejects a natural right to suicide, in his discussion of the state of nature:

But though this be a state of liberty, yet it is not a state of license; though man in that state has an uncontrollable liberty to dispose of his person or possessions, yet he has not liberty to destroy himself, or so much as any creature in his possession, but where some nobler use than its bare preservation calls for it. The state of nature has a law of nature to govern it, which obliges everyone; and reason, which is that law, teaches all mankind who will but consult it, that, being all equal and independent, no one ought to harm another in his life, health, liberty, or possessions.⁵

Admittedly, the argument here turns explicitly theological—we are said to be our wise Maker's property. But the argument against a man's willful "quitting of his station" seems, for Locke, to be a corollary of the natural inclination and right of self-preservation.

Some try to argue, wrongly in my view, that Locke's teaching on property rests on a principle of self-ownership, which can then be used to justify self-destruction: since I own my body and my life, I may do with them as I please. As this argument has much currency, it is worth examining in greater detail. Locke does indeed say something that seems at first glance to suggest self-ownership:

Though the earth and all inferior creatures be common to all men, yet every man has a property in his own person; this nobody has a right to but himself. The labor of his body and the work of his hands we may say are properly his.⁶

But the context defines and constricts the claim. Unlike the property rights in the fruits of his labor, the property a man has in his own person is inalienable: a man cannot transfer title to himself by selling himself into slavery. The "property in his own person" is less a metaphysical statement declaring self-ownership, more a political statement denying ownership by another. This right removes each and every human being from

the commons available to all human beings for appropriation and use. My body and my life are my property *only in the limited sense that they are not yours*. They are different from my alienable property—my house, my car, my shoes. My body and my life, while mine to use, are not mine to dispose of. In the deepest sense, my body is nobody's body, not even mine.⁷

Even if one continues, against reason, to hold to strict self-ownership and self-disposability, there is a further argument, one that is decisive. Self-ownership might enable one at most to justify attempting suicide; it cannot justify a right to succeed or, more important, a right to the assistance of others. The designated potential assistant-in-death has neither a natural duty nor a natural right to become an actual assistant-in-death, and the liberal state, instituted above all to protect life, can never countenance such a right to kill, even on request. A right to become dead or to be made dead cannot be sustained on classical liberal grounds.

Later thinkers in the liberal tradition, including those who prized freedom above preservation, also make no room for a "right to die." Jean-Jacques Rousseau's complaints about the ills of civil society centered especially and most powerfully on the threats to life and limb from a social order whose main purpose should have been to protect them.⁸ And Immanuel Kant, for whom rights are founded not in nature but in reason, holds that the self-willed act of self-destruction is simply self-contradictory.

It seems absurd that a man can injure himself (*volenti non fit injuria* [Injury cannot happen to one who is willing]). The Stoic therefore considered it a prerogative of his personality as a wise man to walk out of his life with an undisturbed mind whenever he liked (as out of a smoke-filled room), not because he was afflicted by actual or anticipated ills, but simply because he could make use of nothing more in this life. And yet this very courage, this strength of mind—of not fearing death and of knowing of something which man can prize more

highly than his life—ought to have been an ever so much greater motive for him not to destroy himself, a being having such authoritative superiority over the strongest sensible incentives; consequently, it ought to have been a motive for him not to deprive himself of life.

Man cannot deprive himself of his personhood so long as one speaks of duties, thus so long as he lives. That man ought to have the authorization to withdraw himself from all obligation, i.e., to be free to act as if no authorization at all were required for this withdrawal, involves a contradiction. To destroy the subject of morality in his own person is tantamount to obliterating from the world, as far as he can, the very existence of morality itself; but morality is, nevertheless, an end in itself. Accordingly, to dispose of oneself as a mere means to some end of one's own liking is to degrade the humanity in one's person (*homo noumenon*), which, after all, was entrusted to man (*homo phaenomenon*) to preserve.⁹

It is a heavy irony that it should be autonomy, the moral notion that the world owes mainly to Kant, that is now invoked as the justifying ground of a right to die. For Kant, autonomy, which literally means self-legislation, requires acting in accordance with one's true self—that is, with one's rational will determined by a universalizable, that is, rational, maxim. Being autonomous means not being a slave to insinct, impulse, or whim, but

the Nietzschean self, who finds reason just as enslaving as blind insinct and who finds his true "self" rather in unconditioned acts of pure creative will.

Yet even in its willful modern meaning, "autonomy" cannot ground a right to die. First, one cannot establish on this basis a right to have *someone else's* assistance in committing suicide—a right, by the way, that would impose an obligation on someone else and thereby restrict *his* autonomy. Second, even if my choice for death were "reasonable" and my chosen assistant freely willing, my autonomy cannot ground *his* right to kill me, and, hence, it cannot ground my right to become dead. Third, a liberty right to an assisted death (that is, a right against interference) can at most approve assisted suicide or euthanasia for the mentally competent and alert—a restriction that would prohibit effecting the deaths of the mentally incompetent or comatose patients who have not left explicit instructions regarding their treatment. It is, by the way, a long philosophical question whether all such instructions must be obeyed, for the person who gave them long ago may no longer be "the same person" when they become relevant. Can my fifty-three-year-old self truly prescribe today the best interests for my seventy-five-year-old and senile self?

In contrast to arguments presented in recent court cases, it is self-contradictory to assert that a proxy not chosen by the patient can exercise the patient's rights of autonomy. Can a citizen have a right to vote that would

My body and my life, while mine to use, are not mine to dispose of. In the deepest sense, my body is nobody's body, not even mine.

rather doing as one ought, as a rational being. But autonomy has now come to mean "doing as you please," compatible no less with self-indulgence than with self-control. Here with one sees clearly the triumph of

be irrevocably exercised "on his behalf," and in the name of his autonomy, by the government.¹⁰ Finally, if autonomy and dignity lie in the free exercise of will and choice, it is at least paradoxical to say that our autonomy licenses an act that puts our

autonomy permanently out of business.

It is precisely this paradox that appeals to the Nietzschean creative self, the bearer of so many of this century's "new rights." As Mansfield brilliantly shows, the creative ones are not bound by normality or good sense:

Creative beings are open-ended. They are open-ended in fact and not merely in their formal potentialities. Such beings do not have interests; for who can say what is in the interest of a being that is becoming something unknown? Thus the society of new rights is characterized by a loss of predictability and normality: no one knows what to expect, even from his closest companions.¹¹

The most authentic self-creative self revels in the unpredictable, the extreme, the perverse. He does not even flinch before self-contradiction; indeed, he can display the triumph of his will most especially in self-negation. And though it may revolt us, who are we to deny him this form of self-expression? Supremely tolerant of the rights of others to their own eccentricities, we avert our glance and turn the other moral cheek. Here at last is the only possible philosophical ground for a right to die: arbitrary will, backed by moral relativism. Which is to say, no ground at all.

Is There a Legal Right to Die?

Such foreign philosophic doctrines, prominent among the elite, are slowly working their relativistic way through the broader culture. But in America, rights are still largely defined by law. Turning, then, from political and moral philosophy to American law, we should be surprised to discover any constitutional basis for a legal right to die, given that the framers understood rights and the role of government more or less as did Locke. Perusal of the original Constitution of 1787 or of the Bill of Rights finds absolutely nothing on which even the most creative of jurists could try to hang such a right.

But the notorious due process clause of the Fourteenth Amend-

ment, under the ruling but still oxymoronic "substantive due process" interpretation, has provided such a possible peg, as it has for so many other new rights, notwithstanding the fact that the majority of states at the time the Fourteenth Amendment was ratified had laws that prohibited assisting suicide. The one "right-to-die" case to reach the Supreme Court, *Cruzan by Cruzan v. Director, Missouri Department of Health* (decided by a five-to-four vote in June 1990) explored the Fourteenth Amendment in connection with such a right.¹² This case may well have prepared the way for finding constitutional protection, at least for a right-to-refuse-lifesustaining-treatment-in-order-that-death-may-occur.

The parents of Nancy Cruzan, a comatose young woman living for seven years in a persistent vegetative state, petitioned to remove the gastrostomy feeding and hydration tube in order that Nancy be allowed to die. The trial court found for the parents but the Missouri supreme court reversed; when the Cruzans appealed, the United States Supreme Court took the case to consider "whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under the circumstances."

At first glance, the Court's decision in *Cruzan* disappointed proponents of a right to die, because it upheld the decision of the Missouri supreme court: it held that Missouri's interest in safeguarding life allowed it to demand clear and convincing evidence that the incompetent person truly wished to withdraw from treatment, evidence that in Nancy Cruzan's case was lacking. Nevertheless, the reasoning of the majority decision was widely interpreted as conceding such a right to die for a competent person—a misinterpretation, to be sure, but not without some ground.

Chief Justice William Rehnquist, writing for the majority, scrupulously avoided any mention of a "right to die," and he wisely eschewed taking up the question under the so-called right of privacy. Instead, following precedent in Fourteenth Amendment jurisprudence and relying on

the doctrine that informed consent is required for medical invasion of the body, he reasoned that "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our previous decisions." (A "liberty interest" is a technical term denoting a liberty less firmly protected by the due process clause than a "fundamental right"; generally speaking, restrictions on the latter may be justified only by a compelling state interest but restraints on the former may be upheld if they do not unduly burden its exercise.) But on the crucial question of whether the protected liberty interest to refuse medical treatment embraces also refusing life-sustaining food and water, Rehnquist waffled skillfully:

Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment [namely, death] would inform the inquiry whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition. (p. 2852) (Emphasis added)

Because the decision in *Cruzan* concerned an incompetent person incapable of exercising "a hypothetical right to refuse treatment or any other right," the right that Rehnquist was willing to assume had no bearing on the decision. But the chief justice could have put the matter differently. He might have said, "Whether or not a competent person has such a right, Nancy Cruzan, being incompetent, does not." True, he drew back from accepting in his own name the petitioner's claim, indicating instead that an inquiry would still be needed to determine whether a state may consti-

tionally deprive a competent person of his "liberty interest" to elect death by refusing artificial hydration and nutrition. But he was willing to stipulate for the purposes of this case—one suspects that he really means for the purpose of getting a majority on his side in this case—a constitutionally protected right-to-refuse-treatment-so-that-death-will-occur. This stipulation, missing the qualification "for the purposes of this case," was heralded in many newspapers and magazines around the country as establishing a constitutional right to die for competent persons.

Justice Sandra Day O'Connor, apparently the swing vote in the case, wrote a concurring opinion solely to indicate why the stipulated right was a right indeed. It is clear from her opinion that, if the case had in fact involved a competent patient, a right-to-elect-death-by-refusing-food-and-water would have been judicially established, for she would have sided with the four-member minority who were ready to grant it even to incompetents:

I agree that a [constitutionally] protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions . . . and that the refusal of artificially delivered food and water is encompassed within that liberty interest. I write separately to clarify why I believe this to be so. (p. 2856)

What Chief Justice Rehnquist treats as hypothetical, Justice O'Connor treats as actual, and she presents her argument for its establishment. In the end she even speaks about the need to safeguard similar liberty interests for incompetents, giving shockingly little attention to the duty of the state to protect the life of incompetent people against those who would exercise on their behalf their putative right to die.¹⁵

Only Justice Antonin Scalia, writing a separate concurring opinion, seems to have gotten it right, insisting that the Constitution has absolutely nothing to say in this matter. He argues, first, that the liberty protected by the Fourteenth Amendment could not and does not include a "right to sui-

cide," and second, that arguments attempting to separate the withdrawal of the feeding tube from Nancy Cruzan from ordinary suicide all fail. He reasons (to me convincingly) that a right to refuse treatment here means necessarily a right to put an end to her life.

What I have said above is not meant to suggest that I would think it desirable, if we were sure that Nancy Cruzan wanted to die, to keep her alive by the means at issue here. I only assert that the Constitution has nothing to say about the subject. To raise up a constitutional right here we would have to create out of nothing (for it exists neither in text nor tradition) some constitutional principle whereby, although the State may insist that an individual come in out of the cold and eat food, it may not insist that he take medicine; and although it may pump his stomach empty of poison he has ingested, it may not fill his stomach with food he has failed to ingest. (p. 2863)

Yet paradoxically, Justice Scalia's powerful argument, which identifies the refusal of food and water as suicide, may come back to haunt us, especially when conjoined with Justice O'Connor's insistence that such right of refusal is already constitutionally protected. For should Justice O'Connor's view prevail, Justice Scalia's powerful intellect will have provided the reasons for regarding the newly protected right as indeed a right to die. The elements are all in place for inventing a constitutional right to suicide and, in the case of incompetents, for assistance with suicide, that is, a right to die. Justice Scalia's worry is not misplaced:

I am concerned, from the tenor of today's opinions, that we are poised to confuse that enterprise [legislating with regard to end-of-life decisions] as successfully as we have confused the enterprise of legislating concerning abortion. (p. 2859)

Almost no one seems to have noticed a painful irony in this proceeding.¹⁶ The Fourteenth Amendment

prohibits the states from depriving persons not only of liberty but also of life and property, without due process of law. A so-called vitalist state, like Missouri, has at least for now been vindicated in its efforts to protect an incompetent person's life against those who assert the superiority of his "liberty interest" to elect death by starvation. But no thought seems to have been given to the conduct of the so-called nonvitalist states, like New Jersey, that go the other way and give the benefit of incompetency to death—all in the name of liberty. In abandoning those vulnerable persons whom others insist have lives no longer worth living, these states come much closer to violating the strict letter of the Fourteenth Amendment's insistence that the state not take life than does Missouri in allegedly thwarting Cruzan's liberty to elect death.

The Tragic Meaning of "Right to Die"

The claim of a "right to die," asserted especially against physicians bent on prolonging life, clearly exposes certain deep difficulties in the foundations of modern society. Modern liberal, technological society rests especially upon two philosophical pillars raised first in the seventeenth century, at the beginning of the modern era: the preeminence of the human individual, embodied in the doctrine of natural rights as espoused first by Hobbes and Locke; and the idea of mastery of nature, attained through a radically new science of nature as proposed by Francis Bacon and René Descartes.

Both ideas were responses to the perceived partial inhospitality of nature to human need. Both encouraged man's opposition to nature, the first through the flight from the state of nature into civil society for the purpose of safeguarding the precarious rights to life and liberty; the second through the subduing of nature for the purpose of making life longer, healthier, and more commodious. One might even say that it is especially an opposition to death that grounds these twin responses. Politically, the fear of violent death at the hands of warring men requires

law and legitimate authority to secure natural rights, especially life. Technologically, the fear of death as such at the hands of unfriendly nature inspires a bolder approach, namely, a scientific medicine to wage war against disease and even against death itself, ultimately with a promise of bodily immortality.

Drunk on its political and scientific successes, modern thought and practice have abandoned the modest and moderate beginnings of political modernity. In civil society the natural rights of self-preservation, secured through active but moderate self-assertion, have given way to the non-natural rights of self-creation and self-expression; the new rights have no connection to nature or to reason, but appear as the rights of the untrammelled will. The "self" that here asserts itself is not a natural self, with the predictable interests given it by a universal human nature with its bodily needs, but a uniquely individuated and self-made self. Its authentic selfhood is demonstrated by its ability to say no to the needs of the body, the rules of society, and the dictates of reason. For such a self, self-negation through suicide and the right to die can be the ultimate form of self-assertion.

In medical science, the unlimited battle against death has found nature unwilling to roll over and play dead. The successes of medicine so far are partial at best and the victory incomplete, to say the least. The welcome triumphs against disease have been purchased at the price of the medicalized dehumanization of the end of life: to put it starkly, once we lick cancer and stroke, we can all live long enough to get Alzheimer's disease. And if the insurance holds out, we can die in the intensive care unit, suitably intubated. Fear of the very medical power we engaged to do battle against death now leads us to demand that it give us poison.

Finally, both the triumph of individualism and our reliance on technology (not only in medicine) and on government to satisfy our new wants-demanded-as-rights have weakened our more natural human associations—especially the family, on which we all need to rely when our pretense to autonomy and mastery is eventu-

ally exposed by unavoidable decline. Old age and death have been taken out of the bosom of family life and turned over to state-supported nursing homes and hospitals. Not the clergyman but the doctor (in truth, the nurse) presides over the end of life, in sterile surroundings that make no concessions to our finitude. Both the autonomous will and the will's partner in pride, the death-denying doctor, ignore the unavoidable limits on will and technique that nature insists on. Failure to recognize these limits now threatens the entire venture, for rebellion against the project through a "right to die" will only radicalize its difficulties. Vulnerable life will no longer be protected by the state, medicine will become a death-dealing profession, and isolated individuals will be technically dispatched to avoid the troubles of finding human ways to keep company with them in their time of ultimate need.

That the right to die should today be asserted to win release from a hyperpowerful medical facility is thus more than tragic irony: it is also very dangerous. Three dangers especially stand out.

First, the right to die, especially as it comes to embrace a right to "aid-in-dying," or assisted suicide, or euthanasia, will translate into an obligation on the part of others to kill or help

knowingly and freely request death. The vast majority of persons who are candidates for assisted death are, and will increasingly be, incapable of choosing and effecting such a course of action for themselves. No one with an expensive or troublesome infirmity will be safe from the pressure to have his right to die exercised.

Third, the medical's profession's devotion to healing and refusal to kill—its ethical center—will be permanently destroyed, and with it, patient trust and physician self-restraint. Here is yet another case where acceding to a putative personal right would wreak havoc on the common good.

Nothing I have said should be taken to mean that I believe life should be extended under all circumstances and at all costs. Far from it. I continue, with fear and trembling, to defend the practice of allowing to die while opposing the practice of deliberately killing—despite the blurring of this morally bright line implicit in the artificial food and water cases, and despite the slide toward the retailing of death that continues on the sled of a right to refuse treatment. I welcome efforts to give patients as much choice as possible in how they are to live out the end of their lives. I continue to applaud those courageous patients and family members and those con-

I continue to insist that we cannot serve the patient's good by deliberately eliminating the patient. And if we have no right to do this to another, we have no right to have others do this to ourselves.

kill. Even if we refuse to impose such a duty but merely allow those to practice it who are freely willing, our society would be drastically altered. For unless the state accepts the job of euthanizer, which God forbid that it should, it would thus surrender its monopoly on the legal use of lethal force, a monopoly it holds and needs if it is to protect innocent life, its first responsibility.

Second, there can be no way to confine the practice to those who

scientious physicians who try prudently to discern, in each case, just what form of treatment or nontreatment is truly good for the patient, even if it embraces an increased likelihood of death. But I continue to insist that we cannot serve the patient's good by deliberately eliminating the patient. And if we have no right to do this to another, we have no right to have others do this to ourselves. There is, when all is said and done, no defensible right to die.

A Coda: About Rights

The rhetoric of rights still performs today the noble, time-honored function of protecting individual life and liberty, a function now perhaps even more necessary than the originators of such rhetoric could have imagined, given the tyrannical possibilities of the modern bureaucratic and technologically competent state. But with the claim of a "right to die," as with so many of the novel rights being asserted in recent years, we face an extension of this rhetoric into areas where it no longer relates to that protective function, and beyond the limited area of life in which rights claims are clearly appropriate and indeed crucial. As a result, we face a number of serious and potentially dangerous distortions in our thought and in our practice. We distort our understanding of rights and weaken their respectability in their proper sphere by allowing them to be invented—without ground in nature or in reason—in response to moral questions that lie outside the limited domain of rights. We distort our understanding of moral deliberation and the moral life by reducing all complicated questions of right and good to questions of individual rights. We subvert the primacy and necessity of prudence by pretending that the assertion of rights will produce the best—and most moral—results. In trying to batter our way through the human condition with the bludgeon of personal rights, we allow ourselves to be deceived about the most fundamental matters: about death and dying, about our unavoidable finitude, and about the sustaining interdependencies of our lives.

Let us, by all means, continue to deliberate about whether and when and why it might make sense for someone to give up on his life, or even actively to choose death. But let us call a halt to all this dangerous thoughtlessness about rights. Let us refuse to talk any longer about a "right to die."

Notes

1. For my "generosity" to succeed, I would, of course, have to commit suicide without assistance and without anyone's discovering it—i.e., well before I were de-

mented. I would not want my children to believe that I suspected them of being incapable of loving me through my inevitable decline. There is another still more powerful reason for resisting this temptation: is it not unreasonably paternalistic of me to try to order the world so as to free my children from the usual intergenerational experiences, ties, obligations, and burdens? What principle of family life am I enacting and endorsing with my "altruistic suicide"?

2. Here is a recent example from a professor of sociology who objected to my condemnation of Derek Humphry's *Final Exit*:

Is Mr. Kass absolutely opposed to suicide? Would he have dissuaded Hitler? Would he disapprove of suicide by Pol Pot? . . . If we would welcome suicide by certain figures on limited occasions, should we prolong the lives of people who lived useless, degrading or dehumanized lives; who inflicted these indignities upon others; or who led vital lives but were reduced to uselessness and degradation by incurable disease? (*Commentary*, May 1992, p. 12).

3. Harvey C. Mansfield, Jr., "The Old Rights and the New Responsibilities: Self-Expression," in *Old Rights and New*, ed. Robert A. Licht (Washington: American Enterprise Institute, 1993), in press.

4. Hans Jonas, "The Right to Die," *Hastings Center Report* 8, no. 4 (1978): 31-36, at 31.

5. John Locke, *Second Treatise on Civil Government*, ch. 2, "Of the State of Nature," para. 6.

6. Locke, *Second Treatise*, ch. 5, "Of Property," para. 27. Emphasis added.

7. Later, in discussing the extent of legislative power, Locke denies to the legislative, though it be the supreme power in every commonwealth, arbitrary power over the individual and, in particular, power to destroy his life. "For nobody can transfer to another more power than he has in himself; and nobody has an absolute arbitrary power over himself, or over any other to destroy his own life, or take away the life or property of another." *Second Treatise*, ch. 9, "Of the Extent of the Legislative Power," para. 135. Because the state's power derives from the people's power, the person's lack of arbitrary power over himself is the ground for restricting the state's power to kill him.

8. See, for example, Rousseau, *Discourse on the Origin and Foundations of Inequality among Men*, note 9, especially paragraphs four and five.

9. Immanuel Kant, *The Metaphysical Principles of Virtue*, trans. James Ellington (Indianapolis: Bobbs-Merrill, 1964), pp. 83-84. My purpose in citing Kant here is

not to defend Kantian morality—and I am not myself a Kantian—but simply to show that the thinker who thought most deeply about rights in relation to *reason* and *autonomy* would have found the idea of a "right to die" utterly indefensible on these grounds.

10. The attempt to ground a right to die in the so-called right to privacy fails for the same reasons. A right to make independent judgments regarding one's body in one's private sphere, free of governmental inference, cannot be the basis of the right of someone else, appointed by or protected by government, to put an end to one's bodily life.

11. Mansfield, "The Old Rights and the New." This permanent instability of "the self" defeats the main benefit of a rights-based politics, which knows how to respect individual rights precisely because they are understood to be rooted in a common human nature, with reliable common interests, both natural and rational. The self-determining self, because it is variable, also turns out to be an embarrassment for attempts to respect prior acts of self-determination, as in the case of living wills. For if the "self" is truly constantly being re-created, there is no reason to honor today "its" prescriptions of yesterday; for the two selves are not the same.

12. 110 S. Ct. 2841 (1990).

13. Justice William Brennan, in his dissenting opinion, denies that the state has even a legitimate interest in—much less a duty toward—someone's life that could ever outweigh the person's choice to avoid medical treatment. And in the presence of a patient who can no longer choose for herself, the state has an interest *only* in trying to determine as accurately as possible "how she would exercise her rights under these circumstances. . . . [U]ntil Nancy's wishes have been determined, the only (!) state interest that may be asserted is an interest in safeguarding the accuracy of that determination." (This is, by the way, a seemingly impossible task, given the view of the self that is implicit in Justice Brennan's reasoning.) Not the security of life but the self-assertion of the self-determining will is, for Justice Brennan, the primary interest of the state. We see here how Nietzschean thinking threatens to replace classical American liberalism, even in constitutional interpretation.

14. A notable exception is Yale Kamisar, professor of law at the University of Michigan Law School. In my view, Kamisar is our finest legal commentator on this subject. His "When Is There a Constitutional 'Right to Die'? When Is There No Constitutional 'Right to Live'?" *Georgia Law Review* 25 (1991): 1203-42.

Mr. CANADY. Mr. Torscano.

STATEMENT OF ROY TORSCANO, REPRESENTING ALBERT ROSEN, M.D., MITCHELLVILLE, MD

Mr. TORSCANO. Mr. Chairman, my name is Roy Torscano, and I am here because Dr. Albert Rosen cannot be here. He is now, I believe, on his deathbed, and I am here to introduce a video interview that was made yesterday with Dr. Rosen in his apartment. I believe if the lights could be dimmed, it would be helpful to the committee.

[Video shown.]

Mr. TORSCANO. Mr. Chairman, if you have questions later, I may be able to amplify on this. I have known Dr. Rosen for several years, and we are 100 percent in agreement on this subject.

Mr. CANADY. Dr. Gomez.

STATEMENT OF CARLOS F. GOMEZ, M.D., ASSISTANT PROFESSOR OF MEDICINE, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE

Dr. GOMEZ. Thank you, Mr. Chairman.

Before beginning I would like to preface my remarks with one disclaimer. I am currently assistant professor of medicine on the faculty at the University of Virginia School of Medicine. Additionally, I serve as medical director of our in-patient hospice and palliative care unit. I serve on the local board of our hospice organization, Hospice of Piedmont, where I also serve as associate medical director. Though my work with these organizations has greatly enhanced and deepened my commitment to the terminally ill, I in no way claim to speak for or on behalf of any of the institutions which I serve. The opinions I express here and in my written testimony are entirely my own.

I am a physician who spends a significant part of his working day caring for terminally ill people and their families. It is work that I find ennobling, enriching, rewarding and unfortunately underrepresented in my profession. I come in contact almost daily with desperately ill people with poorly managed symptoms turning to our profession for help in their final days and weeks. It is these very patients, the terminally ill, those in desperate pain, the isolated and marginalized in our society whom proponents of the assisted suicide would now have us, quote, "aid" toward what is painted as a painless, merciful and, let us be honest here, economical end.

Everything I have learned in acquiring the skills of my profession, all that my patients have taught me, everything that I believe as a citizen of this country convinces me that this would be a public experiment with devastating consequences for the least protected in our society, the aged and infirm, the demented and those just this side of dementia, people with AIDS, women of color who populate the clinics of our public hospitals such as my own, and who teach me on an almost daily basis how tenuous and hard-fought their existence is and how easily they and their families can be dispirited and demoralized into accepting this allegedly merciful end.

I have found that what patients at the end of life require and want more than anything else is a system of medical care that will tend to their needs more than whatever economic or institutional imperative may be at hand. In other words, the terminally ill need palliation in all its many forms.

It is unfortunately a system of care which we American physicians have been slow to understand and at times have resisted outright. It is a system of care which places the experience of the patient and his or her family at the top of our hierarchy of priorities. It is a system which does not view the inevitability of death as a failure, but rather as the natural end of those of us who call ourselves mortal. It is a system of care that doesn't abandon the terminally ill to a panoply of unwanted and futile therapies, therapies that will punctuate the dying process by fits and starts, but will only forestall the inevitable, though only after we have brutalized our patients. It is a system of care that marshals all the resources of medical and nursing systems to make sure that those who are dying are also living well while they die.

And I would like to amend my written testimony briefly to say that I am chilled when I hear the circuit court describing as the State having less compelling interest in the lives of terminally ill people, and I am even more chilled when a representative of the Hemlock Society repeats that. It argues against everything that palliative medicine stands for and argues against everything that I do on an almost daily basis with my medical students and residents.

The lives of terminally ill people are as important as those who have better prospects for life. The devaluation of life at the end of life is one of the problems that has led us, I think, to Kevorkian and others of his ilk.

The second point is that palliative care is not cheap. Since I opened a palliative care unit at the University of Virginia Hospital, I have been audited three times by Medicare, but each time the audit has come out fine, but the auditor has said, you sure do spend a lot of resources on your dying patients, and each time I said, thank you.

Finally, I tell my medical students and patients that life is not a problem to be resolved; it is a task that you need to help patients to live. I will say that again. There is no solution to the problem of life because life is not a problem. It is a task which we have been given, and our job as physicians is to help our patients to live as well as they can until they die.

That we have not yet obtained this sort of system is not in any way to sanction the alternative before this subcommittee, the American courts and the American people. It is, in fact, our most deeply held belief that were we to pursue assisted suicide and euthanasia as our response to the terminally ill, we would soon find ourselves—ourselves, my fellow physicians and allied health care workers—literally putting to death hundreds of thousands of others under the guise of, quote, "mercy and autonomy." If the experience of other countries and other cultures with this allegedly benign practice is any guide, and I have no reason to invoke American exceptionalism in this regard, we will be engaged in a poorly dis-

guised expedience of eliminating the "least desirable," quote/unquote, among us.

Finally, let me conclude with two other comments I would like to amend. I do ask my patients who are terminally ill about suicide on an ongoing basis. Not to do so is to perform a poor clinical act. If they are suicidal, I need to know that. If they are having terminal insomnia, inanition, crying spells, melancholy spells, I need to know that because it needs to be treated just as I would treat you or any other colleague that would come in with depression.

Ladies and gentlemen of this committee, let me reiterate that we stand at a crucial turning point in American history. We now have it well within our technical means to alleviate, to palliate and comfort and control the worst of symptoms of those of our fellow citizens who are terminally ill. The question before this committee and the country at large is whether we have the heart, the courage, and the will to make it so, or whether we will opt for expedience and call it mercy. Few issues, it seems to me, will more fully develop or retard the advance of the American spirit in the next few decades. I hope we will make the wisest and most humane of choices. I urge the committee and those involved in the debate to resist the call for a form of what is essentially licensed killing and take up the harder struggle of caring for the lives of the terminally ill.

Thank you.

[The prepared statement of Dr. Gomez follows:]

PREPARED STATEMENT OF CARLOS F. GOMEZ, M.D., ASSISTANT PROFESSOR OF
MEDICINE, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE

My name is Carlos F. Gomez, and I am honored to have been asked by this committee of Congress, at the invitation of Representative Hyde, to testify before you on this controversial issue of assisted-suicide.

Before beginning, I would like to preface my remarks with one disclaimer. I am currently an assistant professor of medicine, on the faculty at the University of Virginia School of Medicine. Additionally, I serve as medical director of our in-patient hospice and palliative care unit. Moreover, I serve on the board of our local hospice organization — Hospice of the Piedmont — where I also serve as associate medical director. Though my work with these organizations has greatly enhanced and deepened my commitment to the care of the terminally ill, I in no way claim to speak for or on behalf of any of the institutions for which I serve. The opinions expressed below and in my written testimony are entirely my own.

Ladies and gentlemen of this committee, I am a physician who spends a significant part of his working day caring for terminally ill people and their families. It is work which I find ennobling, enriching, rewarding, and — unfortunately — sorely underrepresented in my profession. I come in contact almost daily with desperately ill people, with poorly managed symptoms, turning to our profession for help in their final days and weeks. It is these very patients — the terminally ill, those in desperate pain, the isolated and marginalized on our society — whom proponents of assisted-suicide would now have us "aid" toward what is painted as a painless, merciful, and — let us be honest — economical — end.

Everything that have learned in acquiring the skills of my profession, all that my patients have taught me, everything that I believe as a naturalized citizen of this country, convinces me that this would be a public experiment with devastating consequences for the least protected in our society: the aged and infirm, the demented and those just this side of dementia, people with AIDS, women of color, the indigent and stigmatized who populate the clinics of our public hospitals (such as my own), and who teach me on a daily basis how tenuous and hard-fought their existence is, and how easily they and their families could be dispirited and demoralized into "accepting" this allegedly merciful end.

I have found that what patients at the end of life require — and want — more than anything else is a system of medical care that will tend to *their needs* — the needs of the ill and their family — more than whatever economic or institutional imperative may be at hand. In other words, the terminally ill need *palliation* — in all its many forms. It is, unfortunately, a system of care which we American physicians have been slow to understand, and moreover, have at times resisted outright. It is a system of care which places the experience of the *patient* — and his or her family — at the top of our hierarchy of priorities. It is a system which does not view the inevitability of death as a failure, but rather, as the natural end, the pre-ordained end, of those of us who call ourselves *mortal*. It is a system of care that does not abandon the terminally ill to a panoply of unwanted, and generally futile, therapies, therapies which will punctuate the dying process by fits and starts, but will only forestall the inevitable, though only after we have brutalized our patients. It is, finally, a system of care which marshals *all* the resources of medical and nursing systems to make sure that those who are *dying* are also *living well* while they die.

That we have not yet obtained this sort of system is not, in any way, to sanction the alternative now before this Committee, the American courts, and the American people. It is, in fact, my most deeply held belief that were we to pursue assisted-suicide and euthanasia as our response to the terminally ill, we would soon find ourselves — *ourselves*, my fellow physicians and allied health care workers — quite literally putting to death hundreds of thousands of others under the guise of “mercy” and “autonomy.” If the experience of other countries and other cultures with this allegedly benign practice is any guide (and I have no reason to invoke American “exceptionalism” in this regard), we will be engaging in the poorly disguised expedience of eliminating the “least desirable” among us. This is an argument I develop more fully in my submitted written testimony, and which I will gladly develop orally at this Committee’s pleasure.

Finally, ladies and gentlemen of this Committee, let me reiterate that we stand at a crucial turning point in American history. We now have it well within our *technical* means to alleviate, to palliate, to comfort, and to control the worst of symptoms among those of our fellow citizens who are terminally ill. The questions before this Committee, and before the country at large, is whether we have the heart, the courage, and the will to make it so, or whether we will opt for expedience, and call it mercy. Few issues, it seems to me, will more fully develop, or retard, the advance of the American spirit in the next few decades. I hope we will make the wisest, and most humane, of choices.

I urge this Committee, and those now involved in this debate, to resist the call for a form of what is essentially licensed killing, and to take up the harder struggle of caring for the lives of the terminally ill.

Thank you for your kind attention.



EUTHANASIA:

CONSIDER THE DUTCH

Carlos F. Gomez

How ought we die? Should we decide when and how to die? Should we seek death before it finds us, even as a release from our pains, physical and otherwise? Should physicians be the agents who help us commit suicide?

What was once a small, if insistent, chorus of voices lobbying for legalization of euthanasia has grown in both number and volume. It is a chorus of voices that has newly found legitimacy, and has captured the attention of a serious audience in medical circles. This reawakened interest in euthanasia has also generated political activity, the most prominent of which is Initiative 119, which the voters of Washington state will face this November. The referendum, if passed, would in essence overturn existing laws that prohibit physicians from intentionally killing patients.

The focus of concern in this debate over the permissibility of euthanasia has been those patients afflicted with a terminal disease who are dying a slow, disfiguring death. Exhausted from their struggle, dispirited over their prospects, and facing weeks or months of pain, these patients, it is argued, should be offered something that does no more than hasten the inevitable. If they are competent to make decisions—and if they are so inclined—these patients should be allowed to seek assistance with suicide. More specifically, physicians should be permitted (in the words of the Washington initiative) to “render a medical service” to consenting patients, namely, the proffering of drugs with the sole intent of killing.

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Those who make this argument in favor of euthanasia—especially those now engaged in crafting new legislation in Washington state and elsewhere—proceed from two premises, neither of which is easily refuted. The first is that to end a patient's suffering through euthanasia is a humane and charitable enterprise, that it fits well (or should fit well) with the traditionally accepted role of physician as alleviator of pain. When all else fails—when medicine's curatives and analgesics neither heal nor palliate—the physician should be able to end a consenting patient's suffering by killing the patient. The second premise, which complements the first, exalts the widely accepted principle of autonomy and suggests that freely consenting individuals—physicians and patients—should be relatively unfettered in this manner. If a patient so chooses to end his or her life, and if a physician is a willing participant, then euthanasia is permissible. This argument from autonomy finds bold expression in the words of H. Tristram Englehardt (“Death by Free Choice: Variations on an Antique Theme,” in *Suicide and Euthanasia*, edited by Baruch Brody, Kluwer Academic Publishers, 1989).

An apologist for the practice, Englehardt suggests that against any claims regarding the sanctity of life, counterclaims can be advanced regarding the sanctity of free choice. Another way of putting this is that killing cannot be shown to be a *malum in se*.... What is wrong with murder is taking another person's life without permission. *Consent cures. The competent suicide consents* (emphasis added).

Laws, taboos, and professional canons of conduct that impinge on this freedom, that prohibit what is seen as a charitable act, should be modified or repealed. Moreover, so the argument goes, well-crafted legislation in this area has the added advantage of regulating a practice that occurs with greater frequency and regularity than we care to admit.

I am skeptical of these arguments (even in their most elegant form), and in particular, I am opposed to the end that they serve. There is a suasive power in these images of patients disfigured physically and emotionally by pain and illness, yet I am unconvinced that the proper response—either from the profession of medicine or from society as a whole—should be to assist in suicide. My objections have several sources. Some derive from a basic disagreement with apologists for physician-assisted suicide over what constitutes a fitting role for physicians in society, and what part physicians may and may not play in their patients' lives. Other objections follow from a profound mistrust that what is portrayed as an act of charity is, in fact, beneficent and good: to acquiesce in a demand, however sincere, is not necessarily the same as to act lovingly.

Were I to develop these objections more fully, this would be a rather different article, focusing on matters more philosophical and theological. I leave that important task to my other colleagues writing in this issue of *Commonweal*, and instead concentrate here on more specific worries: What would this newly codified practice of euthanasia look like? Will it be, as its defenders insist, an exercise of last resort, used only under the most rigidly controlled and tightly circumscribed of circumstances? What kinds of patients will ask for euthanasia, and how will we evaluate

their requests? Finally, and most importantly, how will we regulate this practice? How will we assure ourselves that the weak, the demented, the vulnerable, the stigmatized—those incapable of consent or dissent—will not become the unwilling objects of such a practice?

It is this latter concern which makes me most uneasy, and even if I were won over by other arguments, prudence would still bid me to oppose giving public sanction to the practice. The vulnerable among us are already more exposed than the rest to injustice in various forms; some forms of injustice are more onerous and dangerous than others. No injustice, I would contend, would be greater than being put to death, innocent of crime and unable to articulate one's interests. It is the possibility—or, in my estimation, the likelihood—of such injustice occurring that most hardens my resistance to calls for giving public sanction to euthanasia.

Those who are now proposing the decriminalization of euthanasia, however, argue that it is a practice that can, and should, be well controlled. To argue as I do, it is said, is to deny dying patients a needed and welcome option because of misplaced and unfounded fears. There are certainly dangers here, the argument continues, but a mature and democratic society should be willing and able to construct a public policy that enhances the autonomy of these dying patients, while protecting the rights of others. And that, say the proponents of Initiative 119, is precisely what the proposed law in Washington would do.

Of late, it has been at this point in the argument that proponents of euthanasia have pointed to the Netherlands as a model for this sort of practice. Some segments of the Dutch medical profession have practiced euthanasia, more or less openly, for almost two decades. Proponents of euthanasia in the United States look to the Netherlands as evidence that this practice can be well managed, and that it can be restricted to only those patients who are competent to make such decisions. The experience of the Dutch—who form a humane, tolerant, democratic society—should give at least some assurance that this practice does not necessarily degenerate into indiscriminate killing.

The comparison to the Dutch in this matter is an apt one in many ways. The reasoning of those in the United States who defend the permissibility of euthanasia on the grounds that patients should be able to choose the manner and time of their death, for example, is almost perfectly realized in the Dutch acceptance of euthanasia. The Dutch give such weight to the principle of patient autonomy, for instance, that political and legal institutions—such as the courts—have found other competing interests insufficient to override a request for euthanasia. Thus, claims that euthanasia lies outside the ethic of medical practice, or that it creates unjustifiable dangers for vulnerable patients, have been almost completely subordinated to what apologists for the practice cast as the *right* of patients to seek their end through physician-assisted suicide.

There is, moreover, a well-established sentiment in the Netherlands that parallels another argument of those in this country who would decriminalize euthanasia: that there is no distinction between withdrawing life-sustaining medical intervention

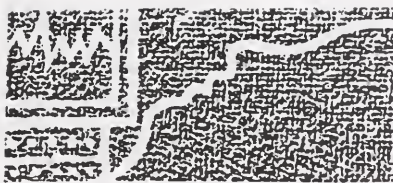
during the agonal stages of a patient's illness and killing the patient outright. Thus, the Dutch have dispensed with the terms "active" and "passive" euthanasia, and use the term "euthanasia" simply and exclusively to denote the physician's intentional administration of a lethal drug at the express request of the patient.

The notion that the practice of euthanasia is one which the medical profession can safely incorporate into accepted standards of care, furthermore, receives support from organized medicine in the Netherlands. The K.N.M.G. (the Royal Dutch Society for the Promotion of Medicine) has advanced euthanasia as a permissible medical practice. The K.N.M.G. has not only drawn up guidelines for acceptable use of euthanasia, it has actively pursued legalization of the practice through the legislative and judicial branches of Dutch government. The K.N.M.G. was instrumental, for example, in lending support early on in the euthanasia movement by intervening on behalf of physicians accused of homicide for practicing euthanasia, and by testifying before government commissions on the desirability of the practice from a medical standpoint.

Thus, proponents of euthanasia in the U.S. are, in one sense, correct in drawing parallels between the aims of their movement and the experience of the Dutch with euthanasia. There is a sort of rough truth to the analogy, and defenders of the practice in this country can rightly point to public opinion surveys in the Netherlands that validate the overwhelming endorsement euthanasia receives from at least two-thirds of the lay public, and perhaps an even higher percentage of the medical profession. They can, moreover, point to repeated assurances from officials in both the government and in private professional organizations that the practice is not being abused. It is argued that the Dutch experiment with euthanasia, which is now several years old, demonstrates that the practice is essentially benign, or at the very least, that it has not degenerated into indiscriminate killing.

My own reading of the situation in the Netherlands, however, is more disturbing, and illuminates a side to this practice that rarely finds its way into public debate. I base my opinions on fieldwork I conducted there in 1989, which involved documenting case histories of euthanasia gathered from those most familiar with the practice: Dutch physicians themselves. The reality of euthanasia in the Netherlands is, I believe, miscast and misunderstood in this country. Were it better appreciated, it would, I believe, give pause to those now seeking public sanction for physician-assisted suicide in this country.

To begin with, euthanasia is still technically illegal in the Netherlands. Through a series of complicated landmark cases which began in 1973, however, the Dutch have created a *de facto* opening to the practice of euthanasia, which rests on the notion that physicians will report their acts of euthanasia to public prosecutors. As the practice now stands, tolerance of euthanasia presupposes that the killing of patients by their physicians will receive some sort of airing, that is, that physicians who practice euthanasia will have to give a public accounting of their actions. The intentional killing of a patient is formally a crime, and in reporting such a case to the district prosecutor (as mandated by court-



established guidelines), physicians must claim not *innocence*, but mitigating circumstances—that they acted, in the words of the K.N.M.G., with their “backs against the wall.” Thus regulation of physician-assisted suicide, to the extent that euthanasia is regulated at all in the Netherlands, rests on the assumption that physicians will incriminate themselves in what is essentially an act of homicide.

It stretches the imagination, however, to believe that a stipulation of this sort provides any sort of regulatory force. Most acts of euthanasia in the Netherlands go unreported and uninvestigated by public authorities. What is more, this is widely known to be the case. There is wide agreement among both defenders and critics of the practice that the nearly two hundred cases of euthanasia reported in 1987 to the Ministry of Justice, for example, represent but a tiny fraction of the actual number of cases. In my own small sample of clinical histories, public prosecutors were notified less than 15 percent of the time. Thus, those in this country who look to the Netherlands for evidence of a well-regulated system of physician-assisted suicide are blithely accepting the assurances of Dutch apologists for the practice, who themselves would be hard-pressed to provide evidence of any sort of formal regulatory oversight.

Nevertheless, those in this country who defend the current euthanasia initiative counter that the Washington state proposal is *codified*, that unlike the Dutch situation, euthanasia in this country would have the added benefit of formal legal sanction. What is implied here is that formal rules, unlike the *de facto* legal situation in the Netherlands, somehow have more regulatory muscle to them. Yet one should note that the Washington proposition is very like the current Dutch arrangement. There is, in fact, no regulatory oversight in Initiative 119. Like the Dutch situation, the Washington proposal gives permission to physicians to perform what was heretofore an illegal act, stipulates punishment should physicians exceed the boundaries of permissible euthanasia, yet does not provide any mechanism of oversight. Like their counterparts in the Netherlands, the citizens of Washington would be subject to a law that is not *constraining*, but *expansive*. Euthanasia would be one more among the options available in a physician's armamentarium.

Some might argue here that the Washington proposal does nothing more than give physicians the same latitude they have with other therapies. But there is a slightly deceptive twist to the Washington proposal. A careful reading of the bill reveals that, remarkably enough, in a case of euthanasia, one could not, under the proposed law, impute that the physician's actions were the proximate cause of death. One suspects that this clause was

inserted to avoid any possibility of criminal proceeding against a physician who followed the guidelines of Initiative 119. What it in effect does, however, is place the actions of a euthanist in a sort of regulatory limbo. It makes it difficult (if not impossible) to discern which deaths in a given time period were due to euthanasia. If “respiratory arrest”—and not the massive overdose of narcotics that led to the respiratory arrest—is the official cause of death in an instance of euthanasia, the most basic of epidemiologic studies would be almost impossible to undertake. Cases of euthanasia would blend imperceptibly into the larger background of deaths resulting from natural causes. Unlike other iatrogenic deaths—poorly tied surgical knots, inadequate or inappropriately administered medicines—euthanasia would escape the sort of rigorous analysis to which the medical profession routinely subjects, for example, its uncomplicated appendectomies.

The significance of this point is not to be minimized, and here again, the example of the Dutch is instructive. If euthanasia is to become, as its defenders suggest, an option of last resort, then a sense of the *numbers* of patients and *types* of patients being killed by their physicians is important. Yet in Holland, this most basic of information is impossible to ascertain with any assurance of accuracy, precisely because physicians misrepresent themselves on the death certificates. Moreover, absent this sort of essential information, more complicated epidemiologic information becomes a matter of guesswork and speculation.

Proponents of euthanasia here and in the Netherlands use this ‘accuracy’ to their advantage in at least two ways. First, the numbers of patients killed by euthanasia each year are—at least to my mind—consistently underrepresented, because they are based not on mortality statistics but on estimates from surveys. In various articles and forums, for example, Dutch apologists for the practice suggest that euthanasia accounts for, at most, 2 percent to 3 percent of all deaths in the Netherlands. In a country with a published mortality rate of 120,000, this would mean that anywhere from 2,400 to 3,600 people die in the Netherlands from euthanasia each year. This number is used by defenders of the practice—both here and abroad—to demonstrate that euthanasia would be little more than a statistical blip—essentially undetectable—on a country's already established mortality rate. But to give the Dutch estimates of the prevalence of euthanasia some perspective, one should note that if this rate of euthanasia were to take hold in the United States (with an annual mortality rate of approximately 2 million deaths per year), a “small” number of deaths from euthanasia would represent 40,000 to 60,000 people killed each year by their physicians.

Secondly, it is important to keep these numbers in mind—even if they are, as I suggest, underestimates—because apologists for the practice suggest that not only are the numbers of people who die, or would die, from euthanasia small, evidence of abuse of the practice is even smaller. That is to say, most of this “small” number of people killed by euthanasia ardently requested to be put to death, were of sound mind, had no other options available,

and so on. And to be fair, in my own sample of cases of euthanasia from the Netherlands, most cases did fit the criteria established by the courts and the Dutch medical profession. Yet there were enough cases—four out of twenty-six, to be exact—in which it was clear that the patient was incapable of giving consent, or in which it was doubtful that consent could have been obtained properly. In none of these cases, by the way, was the public prosecutor notified.

This raises, finally, the question of how well this practice can genuinely be regulated, and what this society would accept as a tolerable degree of assurance that its most vulnerable people—the weak, the unconscious, the demented, the socially stigmatized and marginalized—would be well protected from an unwanted death. If one were to assume that the accepted prevalence rates of euthanasia in the Netherlands would take hold in the U.S., then how many of the projected 40,000 to 60,000 deaths from euthanasia per year would we be willing to accept as “mistakes”? Even a relatively small percentage—say 1 percent—would mean that 400 to 600 people would die, innocent and unwilling, at the hands of physicians. And even that number, I suggest, would underestimate the proportions of the crime.

Those who now face the choice of the legalization of euthanasia in the state of Washington should, I submit, look at the issue with greater care. Moreover, if they use the Netherlands as a model, they might do well to take a second look, and see if the experience of the Dutch might better serve as a cautionary tale. To construct this matter of euthanasia as merely a question of patient autonomy is, I believe, to give short shrift to those who cannot be truly autonomous. The fact that these people are voiceless—that they do not vote, do not write or read articles, cannot advance their own interests—makes them particularly worthy of our concern. The practice of euthanasia—at least as currently envisaged for the state of Washington—would place these patients at intolerable risk. And if, as I have suggested, the Dutch—with their generous social services and universal health-care coverage—have a difficult time controlling the practice, it takes little imagination to see what might easily happen here, with a medical system groaning under the strain of too many demands on too few resources.

Those who would suggest that I am an alarmist—that I am raising the specter of “mercy-killing,” with all its ugly and painful historical baggage—should stop to consider the *current* condition of vulnerable patients in this country. One needs only to walk some afternoon through the back wards of the larger municipal hospitals in this country to get an idea of how tenuous these patients’ existence already is. To suggest that euthanasia would be anything but an unjustifiable danger to these patients is to close one’s eyes to reality. The cries of those who die in pain and despair, amid the studied indifference of professionals whose duty it is to attend to their needs, should be heard. That their cries are gaining in intensity—that some segments of society feel that they should have the option of being helped in their suicide—stands as a reproach to us. What I ask, however, is that those desperate cries for release from pain be balanced against the needs of the voiceless, who even in their silence, still have a right to live. □



WHY DOCTORS

MUST NOT KILL

Leon R. Kass

Do you want your doctor licensed to kill? Should he or she be permitted or encouraged to inject or prescribe poison? Shall the mantle of privacy that protects the doctor-patient relationship, in the service of life and wholeness, now also cloak decisions for death? Do you want *your* doctor deciding, on the basis of his own private views, when you still deserve to live and when you now deserve to die? And what about the other fellow’s doctor—that shallow technician, that insensitive boor who neither asks nor listens, that unprincipled money-grubber, that doctor you used to go to until you got up the nerve to switch: do you want *him* licensed to kill? Speaking generally, shall the healing profession become also the euthanizing profession?

Common sense has always answered, “No.” For more than two millennia, the reigning medical ethic, mindful that the power to cure is also the power to kill, has held as an inviolable rule, “Doctors must not kill.” Yet this venerable taboo is now under attack. Proponents of euthanasia and physician-assisted suicide would have us believe that it is but an irrational vestige of religious prejudice, alien to a true ethic of medicine, which stands in the way of a rational and humane approach to suffering at the end of life. Nothing could be further from the truth. The taboo against doctors killing patients (even on request) is the very embodiment of reason and wisdom. Without it, medicine will have trouble doing its proper work; without it, medicine will have lost its claim to be an ethical and trustworthy profession; without it, all of us will suffer—yes, more than we now suffer because some of us are not soon enough released from life.

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Mr. CANADY. Thank you. Again I want to thank each of the members of this panel for your testimony. It is helpful, excellent testimony from each of you.

Bishop SPONG, let me ask you this: According to a 1991 resolution approved by the General Convention of the Episcopal Church of the United States, "It is morally wrong and unacceptable to take a human life in order to relieve the suffering caused by incurable illness," closed quote.

Is that still the position of the General Convention of the Episcopal Church of the United States?

Bishop SPONG. As a matter of fact, I voted favorably on that resolution. I changed my mind in the intervening years. It is going to be up for a very large debate in 1992.

Mr. CANADY. But that still is the position of the Episcopal Church?

Bishop SPONG. Yes. That is not however the position of the diocese of Newark.

Mr. CANADY. Let me refer to something you said. You referred to the gift of modern technology in your testimony. Exactly what did you mean by that?

Bishop SPONG. In addition to being the Bishop of Newark, I am also the chairman of the board of a hospital in Jersey City, and I live with this sort of decision constantly. The diocese of Newark decided that we needed to study this in light of our understanding of the Christian Gospel. We appointed a task force made up of doctors, lawyers and chaplains who conducted that study and reported it to our convention this past year. Our convention is some 600 people.

The debate was as good a debate as I have ever presided over in which I did not participate, and the vote was somewhere between two-thirds and three-fourths positive for that report. Now, that issue will now go before the National Convention of the Episcopal Church in 1997 and will be debated there.

Mr. CANADY. What are the recommendations contained in that report?

Bishop SPONG. Those recommendations I have sent to this committee. They basically would refuse to allow this unless the person chooses it. When I hear all of the various traditions or various things said throughout the panels all afternoon, that it is going to be something done to somebody against their will, you will find us totally opposed to that. All we are asking for is that there be a legal and moral right for an individual who wishes to do so to manage his or her own death appropriately.

Mr. CANADY. You would oppose allowing euthanasia for the incompetent?

Bishop SPONG. Absolutely. I would also urge that living wills, be mandatory so that the ability to state that decision prior to extremis, be encouraged, throughout this country so that we do not operate in vacuums.

Mr. CANADY. What did you mean by a "gift of modern technology"? Hemlock has been available for a long time.

Bishop SPONG. I don't mean that. I mean the gift of modern technology to postpone death almost interminably. It is the positive aspect of modern technology that I think has separated the preserva-

tion of life from the postponement of death. And I think that is a very crucial line. When you cross that line. New circumstances which require new decisions must be faced.

I am in favor of prolonging life for as long as possible because I do think life is sacred. I am not in favor of postponing death. And I do believe that the decision or the difference between active and passive euthanasia has been rendered inoperative by modern technology.

Mr. CANADY. So you believe that this should be allowed only when the person who is to receive the benefits of this procedure requests it?

Bishop SPONG. Absolutely.

Mr. CANADY. Do you believe that the people who are not terminally ill, but are incapacitated physically, handicapped, perhaps in great pain, should be allowed the option of assisted suicide?

Bishop SPONG. I think everyone should have the option to determine how that person shall die.

Mr. CANADY. So you would extend it, the right to assisted suicide, to any competent person regardless of that person's physical condition?

Bishop SPONG. I tried to separate the concept of suicide earlier. Suicide, when it is an act of self-destruction, when it rises out of depression, or when it rises out of what Freud called the death wish, I think that it is our responsibility as guardians of life to do everything we can to preserve life, to bring health to enable depressed people to come out of depression, not to make inappropriate decisions.

Mr. CANADY. I understand that, but aside from the term of "suicide," say assisted death, would you believe that that is a right that any competent person should have regardless of that person's physical condition?

Bishop SPONG. Let me say that it is a right that I would want to exercise as one human being. I want the right to determine how I shall die, when I have not many other choices. When I have been told that I have got a terminal disease and I have x number of weeks or months to live and what the process is going to be, I want a right to make a legal and moral decision for myself in conjunction with people I know best and love most deeply. I am fortunate enough to have a doctor in whom I have absolute confidence. I do believe that is a vanishing value in the American medical profession today.

Mr. CANADY. Mr. Frank.

Mr. FRANK. I will defer to the chairman since I just got here.

Mr. CANADY. Mr. Hyde.

Mr. HYDE. Well, I didn't get here much before you did.

Mr. FRANK. No, but I was careful and let you beat me, Henry.

Mr. HYDE. Dr. Gomez, I have always been interested in the phrase "potential human life." I have viewed that as kind of an oxymoron. An embryo, blastocyst, then an embryo and a fetus, I view that as human life, not potential human life. It is human. It is not animal, vegetable or mineral. It is alive, it is growing, and it has potential. So it is human life with potential. It is not fully developed, but it is not potential human life.

That seems to diminish the mystery and the wonder of this entity that is growing, and alive, and a member of the human family. So when I read a statement, who has the right to make decisions about life that is only potential, I don't know how you could have life that is human and have it only potential. It has potential, but it is there. It exists, and it is alive; is it not?

Dr. GOMEZ. You are not going to get an argument from me on that.

Mr. HYDE. That is why I asked you.

Dr. GOMEZ. My concern with this question of what is a compelling State interest in life has bothered me for a long time, and now when I see it in this manifestation in the circuit court opinions that suggest that the State has less of a compelling interest in terminally ill patients, that should make us shudder. If you want to provide terrible medical care, make sure that every medical student and resident in this country understands that they have less of a compelling interest in the terminally ill; and then you will have not only assisted suicide, but you will have euthanasia by droves.

Mr. HYDE. I agree, and I think that is an interesting and important question. John Donne, the great poet, said, "Every man's death diminishes me for I am involved in mankind." And the State ought to have, as its premise, the defense of its citizens, of its members, members of the State. And that is why I have always been bothered by the privacy license for justification for abortion, because I am with Arthur Miller; "Attention must be paid." He is not a dog dropping in his grave unnoticed, he is a human being, and attention must be paid.

Thank you, Doctor. I appreciate it. I have no further questions.

Mr. CANADY. Mr. Frank.

Mr. FRANK. Thank you.

One question that concerns me, and it is a case where the intersection of legal and medical—it does—I guess, I would ask those who are opposed to assisted suicide, because if people don't oppose assisted suicide, this would not be hard for them, but do you agree that a doctor has the right to withhold treatment when that would clearly be lifelong? With the approval of the patient, obviously.

Dr. BRISTOW. Mr. Frank, I certainly agree that a doctor is ethically within his or her rights to withhold treatment at the request of the patient.

Mr. FRANK. I want to make clear, when I say "the right," I mean that you would not be legally punished for it, as opposed to something affirmative. You would agree that a doctor shouldn't be subject to legal punishment for refusing, for declining at the request of the patient to offer treatment that would, in fact, prolong life?

Dr. BRISTOW. Also, it is fortunate that it is legally—

Mr. FRANK. I understand, but I am talking about what it should be.

Dr. BRISTOW. The medical profession doesn't try to set what the laws are.

Mr. FRANK. Excuse me? Doesn't try to set what the laws are? You have a bunch of doctors sneaking around behind your back to my office trying to set what the laws are. I am going to report them to you. Maybe you ought to disband your PAC.

Dr. BRISTOW. The point I am trying to make is that we feel responsible for defining what is right.

Mr. FRANK. I understand. But that is not what we are talking about here. We are talking about what public policy ought to be, and I have to say that the notion that doctors are not trying to set the law with regard to medical care is a startling one to me.

Let me ask Dr. Kass the same question.

Dr. KASS. I think since patients have a legal and moral right to refuse treatment, even life-sustaining treatment, it is both legally and morally right for the physician to respect that right.

Mr. FRANK. At the point—this is for everybody—even at the point at which the patient is now not conscious anymore? If the patient was clear enough beforehand, does that bind you afterwards?

Dr. KASS. You mean if there is an advanced directive or a living will, or in the absence thereof?

Mr. FRANK. The patient said—met the legal thing in that State and said, I just want you not to do that.

Dr. KASS. As a matter of principle, yes; but in practice, everybody who has dealt with this knows how delicate it is.

Mr. FRANK. I understand. But in principle, yes.

Dr. Gomez.

Dr. GOMEZ. I agree with what has been said before, and one of the reasons that I can do that and feel all right—not great, but all right—about doing that is at least the patient has the protection of their natural pathology. I do not have to interfere in order to kill.

Mr. FRANK. But I think that is getting to a difference that is diminished in moral significance.

Dr. GOMEZ. Absolutely not.

Mr. FRANK. Excuse me, Doctor. I know you disagree, and I assume you had time to testify, and I am now explaining why I strongly disagree with you. Because the protection of my natural pathology when it is, in fact, killing me and subjecting me to great pain is a protection I would like to be able to forbear in some cases.

But I think that the moral distinction—let me put it this way: Let's take nonmedical situations. If I come upon someone who is about to lose his or her life, and I could easily remedy that condition, it is almost the same as causing it, letting someone helpless drown in a pool. In fact, there are even some legal—it might not be criminal, but some civil liabilities.

The moral distinction between allowing someone to die when it could easily be prevented at that time—life could be prolonged—because the person asked you and helping it along seems to me to be a very difficult one morally.

Certainly from the standpoint—I understand there are practical differences, but you have someone who—I mean, we have said life is very important, and it is precious. If that is the case, and you say people who are under these great stresses and strains, some people they don't know have autonomy, and they don't know who they are, and they can't make these decisions; but if we are willing to make—should people make the decision to die and not others, and it turns on what is from their standpoint an accident over which they have no control, if they are, in fact, about to die, and you could stop them from dying, but they want to die because they

think things are so terrible, and you can do it by not taking care of them when they pass out, that is OK, but helping them is not, that, it seems to me, is a moral distinction of no great weight. And what it basically says is it is as long as I am not involved. I am washing my hands of this.

Mr. CANADY. The gentleman will have 2 additional minutes.

Mr. FRANK. I could stop this from happening. It might happen in a week or a month, but I could stop it now, but I am not going to. I am going to let this person die because the person asked me to die. But that is OK because I didn't do anything. I am a passive actor.

The moral distinction between withholding your services when they could prolong life at the request of this individual and intervening to hasten the ending of life seems to me to be one that is more concerned with keeping the conscience of the actor clear rather than anything that really affects the outcome. I would be interested in your response.

Dr. BRISTOW. Thank you Congressman. I would be happy to respond to that.

There are several aspects you should consider. Many believe that the end does justify the means; that simply you have the same end, therefore that any means by which you approach it is perfectly all right—

Mr. FRANK. Excuse me, Doctor. You misapprehend me. I am not saying that the end justifies means, but as between the means of standing idly by when you have the ability easily to prevent something and helping it happen, that is not a significant difference in the means. It is precisely what I am trying to do is equate the means.

Dr. BRISTOW. Well, there are three aspects. The first I have mentioned. The second aspect of that is that the individual who finds themselves in that position has to consider actions that are taken against the will of the patient as being, in my view, assault and battery. And so, it is perfectly sensible to me to not do something on the basis of the request of the patient that makes—

Mr. FRANK. Excuse me, you are trying to, I think, hide the philosophical point behind a technical legalism. I am talking about whether the law should or should not allow that. We are not talking about—you are talking about a statutory difference. I am talking about whether the law should or shouldn't make that distinction. You said the law should make the distinction because the law does make the distinction. My question is should the law make the distinction.

Dr. BRISTOW. Well, the third part of that is what you are talking about actually does happen. When a person comes into an emergency room who has attempted suicide, and they are unconscious, every effort is made to try to resuscitate and revive that person. And they, at least in my State, are not released from custody until there has been some determination that they are no longer in imminent danger to themselves. So society does take the step that you are talking about.

Mr. FRANK. So that goes back—and I would ask for 30 more seconds—that takes back what people have said before. You are saying that I don't have the right to commit suicide by myself. What

you are in favor of is to keep me under some physical restraint so that I cannot individually and on my own decide to do that. That means you are going to physically prevent me from doing what I might do on my own.

Dr. BRISTOW. I am simply reporting the way it is.

Mr. FRANK. But you have an obligation to talk about more than what it is. We are talking about what it should be.

Mr. CANADY. It is Mr. Hyde's turn.

Mr. HYDE. People change their minds. People who are suicidal suddenly decide that life is worth living. I remember one of the saddest things I saw was on the wall of the Fairmount Hotel in San Francisco. It was an old newspaper, a picture of the bridge, the Golden Gate Bridge, and the story of a young college girl who had jumped off and killed herself over a love affair. And I thought, my God, had she waited and hung in there or been with the right people, she might be married with six kids today, wondering what she was upset about.

And the law has to allow for these things. Doctors prayerfully should be nurturers and healers and alleviators, not social engineers or executioners, and that is the finest, in my opinion, tradition of the medical profession, which you are an exemplar.

Dr. BRISTOW. Thank you.

Mr. HYDE. I yield.

Mr. FRANK. The point is I don't see how that jibes if you believe that, and I would agree someone who is clearly terminally ill and there is not a doubt about that, you are unlikely to succeed. But I don't understand the moral distinction between acquiescing by giving someone the extra pills or simply saying, OK, we are going to let you die, when I could stop it; certainly not from the standpoint of the patient. I don't understand it.

Dr. KASS.

Dr. KASS. If you look only at the result, I don't think you see a difference, but it seems that the moral assessment of any action includes the intent and the proper way to describe it.

Mr. FRANK. The intent is identical.

Dr. KASS. That is what I am disputing with you; it is the brunt of my testimony on this point. It seems to me that the right to refuse medical treatment is not rightly understood as a right to become dead, but, in fact, a right to determine how it is one is going to choose to live even while dying. If one chooses to say, "I want the doctors to stop invading my body. They have had a trial of therapy; it has not worked; even the feeding tube is now futile; and I have had enough," that seems consistent with the principle which underlies the notion of informed consent; namely, that you don't invade a person's body without consent.

Each person has a right to determine how they live even when they are dying, whereas the right claimed under the new dispensation is the right to become dead, by assistance if necessary. That is a radical——

Mr. FRANK. I don't think it is at all. You are imputing to someone a hypersophisticated analysis that they are making. It may be some people who ask to you stop because they don't like this tube. But there are people who say—Elizabeth Bouvia—I want to die.

I factually disagree with you. You said the intent is different. The intent of the patient is to die in both cases.

Dr. KASS. Maybe.

Mr. FRANK. In some cases. "Maybe" means that in some cases you agree with me, and in those cases the patient is not saying you stop invading my body. The patient says is forget your knowledge and your skills, I want to die, and you will say, OK, I will let you die. And I don't think that the intent there is any different whatsoever.

Dr. KASS. Well, it seems to me that the intent of the physician under those circumstances is to do what both Dr. Bristow and Dr. Gomez so beautifully described, which is to never abandon the patient and keep company with them, provide palliative care, and the physician need not embrace the patients wish for death to acquiesce in the patient's demand for the withdrawal of treatment.

Mr. FRANK. But the physician knows that he is, in fact, doing that. At some point we ought to speak clearly. You know that that is, in fact, what you are doing. I just think that you are trying to talk your way around the reality because maybe it is too unpleasant to confront, but that is what you are doing.

Dr. KASS. I am sorry. I think you are trying to confuse the reality and make it somewhat simple. You said in an earlier session that you saw a distinction without a difference between the non-criminalization of, say, suicide and a right to—let me pursue this.

Mr. FRANK. I was wrong when I said that. I was wrong when I said—there is a difference between a mandated right and simply not being subjected to a criminal penalty.

Dr. KASS. When you repeated it, you talked about people being somehow entitled to opt for death. If there is an entitlement to opt for death, then someone has an obligation to meet that entitlement. But if you don't think that people have a tort claim against nature to die when they choose, then no one has an obligation to come in there—

Mr. FRANK. I am entitled to free speech, but you don't have any obligation to help me. I am entitled—when I talked about individual, I mean that I have a right to do whatever I can do to achieve it. That doesn't give me a claim against somebody else. You are obviously changing the subject. I admit I spoke sloppily before. The fact that you want to change the subject strikes me.

I want to get back to it. The question is you are denying—I understand doctors used to be ambivalent about this. Doctors have acquiesced that you are as a doctor, under the law and by ethics, to allow someone to die even though you can prevent it because that individual wishes to die. You say, no, I am not allowing the person to die. I am no longer invading the body. But you and I know that that is what is happening. That is often the motivation; people wanting to die.

Dr. GOMEZ. There is a distinction between what the likely ends are. I have removed patients from ventilators who walked home. I did a home visit on Saturday with a lady who requested to be taken off the ventilator, completely sure, as was I, she was going to die, and lo and behold she is still living.

Mr. FRANK. Completely sure, as you were?

Dr. GOMEZ. Yes.

Mr. FRANK. But that is my point. From your standpoint——

Dr. GOMEZ. I had to acquiesce to something that I felt uncomfortable with, but the law said that she was well within her rights to request what is intrusive and invasive—let me finish—and the distinction here is that I didn't give her a bolus of potassium chloride. I simply disconnected the ventilator and continued to treat her in other ways that she wanted.

Mr. FRANK. That is a different story. I am talking about you——

Dr. GOMEZ. But I told her I thought she would die.

Mr. FRANK. Excuse me. You picked your example to make the point because she wanted treatment in another way. That is clearly a different situation. You said she wanted to be treated in another way.

Dr. BRISTOW. But it is really not a rarity——

Mr. CANADY. The gentleman's time has expired. I recognize Dr. Bristow.

Dr. BRISTOW. I want to support what Dr. Gomez is saying. It is not a rarity to have patients taken off——

Mr. FRANK. I agree, but it does not go to the philosophical point.

Mr. CANADY. The gentleman's time has expired.

Dr. Bristow? Go ahead.

Dr. BRISTOW. I was simply saying that it is not a rarity for patients to be taken off of life support and to survive. Frequently the estimate as to whether or not survival is going to occur is a statistical estimate, and one will say there is a slight chance that person will survive, and, in fact, they do. For that individual patient, obviously it is all important that they have an opportunity to pull through.

The one little point that I wanted to make was that I think you should keep in mind that doctors take care of patients one patient at a time. We do not take care of "populations."

And so for us it is an intense battle. Sometimes we are accused almost of taking it personally when patients die. We do. I think we are supposed to, as Dr. Gomez so beautifully explained. We are health coaches in the game of life. We are supposed to root for our patients, so don't put us down for doing that. That is what we are here for.

Mr. CANADY. Dr. Kass, did you have anything else you wanted to say?

Dr. KASS. Only one thing, I think, Mr. Chairman. It does seem to me—I think the point hasn't been stressed enough, and it was in my oral testimony, that the State—if this new change—if assisted suicide becomes legal, the State will for the first time have abdicated its monopoly on the legitimate use of lethal force, and that is an extremely dangerous thing. It changes the entire nature of the society. And the avoidance of mischief depends on the fragile virtue of the people in whom we put this power. The Dutch have provided us with ample evidence of why we should not do it.

Mr. HYDE. Mr. Chairman, the ninth circuit in its opinion says, "We also realize the terminally ill patients may well feel pressured to hasten their deaths not because of improper conduct by their loved ones, but rather for the opposite reason, out of concern for the economic welfare of their loved ones. Faced with the prospect of astronomical medical bills, terminally ill patients might decide

that it is better for them to die before their health care expenses consume life savings they plan for their families, or, worse yet, burden their families with debts they may never be able to satisfy.

"While State regulations can help ensure that patients do not make rash, uninformed or ill-considered decisions, we are reluctant to say that in a society in which the cost of protracted health care can be so exorbitant, it is improper for competent terminally ill adults to take the economic welfare of their families and loved ones into consideration."

I just say, I can see the dollar signs. The pressures will be almost irresistible on some poor 80-year-old who has fallen and broken a hip, and the kids are there. Take the comfortable way out and get the injection and goodbye. The pressures are going to mount, absolutely mount. And the notion that God—forgive me for mentioning the word "God"—has something to do with the tenure of one's life will be subordinated and sublimated to the account sheet.

So that is what I fear. And I am getting old. I am 72. I can see myself with family around saying, "Dad, do the right thing. Take a hike." And we better think about that, because it really is not funny.

Thank you.

Mr. CANADY. Thank you, Mr. Hyde. I want to thank all the members of this panel. Your testimony has been very valuable. We thank you, and the subcommittee is adjourned.

[Whereupon, at 4:58 p.m., the subcommittee adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING

DAVE CAMP
4TH DISTRICT, MICHIGAN

MEMBER:
COMMITTEE ON
WAYS AND MEANS

SUBCOMMITTEE ON
TRADE

SUBCOMMITTEE ON
HUMAN RESOURCES

Congress of the United States
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April 29, 1996

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I would like to thank Chairman Canady and the members of the Subcommittee on the Constitution for holding this hearing on assisted suicide.

For several years now, the people of Michigan have watched with fascination, horror, and amazement at the debate over assisted suicide that has gripped the state. We have argued the issue on moral, ethical, and even emotional levels. Our courts and state legislature have grappled time and again with the issue, only to find themselves back at square one.

At the same time that Michigan has struggled with this difficult and painful subject, other states across the U.S. have found themselves caught in the same web. For example, the 9th Circuit Court recently struck down the State of Washington's ban on physician-assisted suicide, ruling there is a constitutional right. This ban was put in place by the residents of Washington, who disapproved of physician assisted suicide in their state. And in Oregon, where voters have passed a law legalizing assisted suicide, the state's Medicaid director insisted that physician assisted suicide could be covered by Medicaid funds.

The U.S. Supreme Court will ultimately rule on the constitutionality of assisted suicide. I introduced the Integrity in Medical Funding Act of 1996 to prohibit any federal taxpayer funds from being used "for the purpose of causing, or assisting in causing, the death, suicide, euthanasia or mercy killing of a person." I strongly believe that the federal government should promote policies that seek to protect and enhance lives, not end them.

In addition to restricting the use of taxpayer funds, this legislation prohibits the government from requiring hospitals or their employees to inform or counsel patients about assisted suicide. It would also lift malpractice caps in instances where "assisted suicide was administered, or where life-saving services were intentionally or involuntarily withheld, for the purpose of causing death." These provisions help ensure that those opposed to assisted suicide for moral or ethical reasons would not be forced to counsel others on the subject, and hospitals and doctors would be held accountable to family members were they to assist in causing the death of a patient against that person's will.

The issue of assisted suicide is a difficult topic of discussion for many people. It is a heart wrenching issue for those whose loved ones may be contemplating this option. I do not believe that the federal government should in any way be involved in this decision; this issue should be left to the people of each state and their individual state legislatures to decide.

I also do not believe that the federal government should play any role in subsidizing this option. There are tens of millions of people across this nation who find themselves morally or ethically opposed to the idea of assisted suicide. It should not be within the federal government's powers to force their tax dollars to pay for this choice.

This will not be the first time that Congress votes on the issue of taxpayer funding for assisted suicide. I previously included this provision in the Medicare Preservation Act, which was included in the Balanced Budget Act. The provision was eventually deleted from the Balanced Budget Act by the Senate due to procedural rules. The support was there the first time around to include this provision in these bills, and I believe it will be there for the Integrity in Medical Funding Act.

I do not propose to answer all of the questions posed by those following this debate. I believe that whether states allow assisted suicide or not will ultimately be decided by individuals, their state governments, and the Supreme Court. But what I hope to do is protect American taxpayers from subsidizing an act many cannot, and would not, in good conscience support.

I again thank Chairman Canady for his efforts to bring this issue to forefront of debate and look forward to working with him and the members of this committee in addressing this issue.



MICHIGAN HANDICAPPER
CAUCUS

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STATEMENT OF THE MICHIGAN HANDICAPPER CAUCUS OF THE MICHIGAN DEMOCRATIC PARTY FOR THE HOUSE CONSTITUTIONAL COMMITTEE HEARING ON ASSISTED SUICIDE.

Our organization is the Michigan Handicapper Caucus, a caucus of people within the Michigan Democratic Party representing the rights of those with handicaps.

There may be some confusion about the use of the word "handicapper" in our name. In Michigan years ago, some activists decided that terms like "the handicapped" or "the disabled" were demeaning, because they completely identified individuals with their physical or mental problems. Some believed a better word was "handicapper", a sports term meaning "one who competes with a handicap." This word became common in Michigan and was incorporated in one of the first state bills banning discrimination on the basis of handicap -- the Michigan Handicapper Civil Rights Act. We decided to use it in our name.

Another thing must be emphasized. All too often advocates of assisted suicide have stereotyped their opponents as part of the religious right. In doing so, Jack Kevorkian, Geoffrey Fieger and shockingly even officials of the Michigan chapter of the American Civil Liberties Union have indulged in tactics that are all too similar to the late Senator Joseph Mc Carthy. All too often, they have been aided by members of the media, that have consistently failed to give fair coverage to the concerns of organizations representing the rights of those with handicaps. All too often, in trying to get media coverage on this issue, we have felt as if we had run into an iron curtain.

Perhaps we can serve as a living refutation of stereotypes linking opponents of assisted suicide with the religious right. We are members of the the Democratic Party. On most issues, we consider ourselves liberal. Our members are of different religions. Yet we have not only written against the prominent plans for assisted suicide or testified before public hearings, but filed friend of the court briefs in our courts of law. I hope this establishes this is a bipartisan issue that sincere people of different political views and religious beliefs are involved with.

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One must add that we represent individuals with handicaps, who are most likely to be affected by assisted suicide. Jack Kevorkian, for instance, has declared in late 1992 on TV, for all the world to hear, that he wants assisted suicide not only for those who are terminally ill, or those in constant physical pain, but individuals with handicaps facing emotional pain.

Our most pressing concern is that if it is declared a constitutional right to participate in active killing, under the pretext of assisted suicide, how will we protect the freedom of choice for the vast majority of people who want to live?

A cartoonist recently expressed this dilemma in humorous form. He showed a lawyer using the "Jack Kevorkian defense", declaring before the court, "My client did not murder the party store clerk. He simply assisted in her suicide."

As I am sure you know, in all criminal cases, the criminal must be proven guilty beyond a reasonable doubt. If assisted suicide is declared legal, will not it be the burden of the state to prove beyond a reasonable doubt that the patient did not want to die?

With a young person, who is currently able bodied and in the prime of life, such doubts may be seem very unreasonable indeed. For those with illness or handicap, subject to prejudice by those in society, such doubts may seem much more reasonable. In such cases, what assurances can be given that a person was really "assisted" rather than rudely shoved into the Great Beyond?

The American Civil Liberties Union has given lip service to the idea of regulations regarding assisted suicide. However, the ACLU itself demanded laws against assisted suicide be overturned as unconstitutional, but did not ask the court to insert any regulations on the practice. The ACLU doctrine would have left no restrictions on helping people to die, but would have provided no assurances that they wanted to go. When confronted with this, the Director of the Michigan ACLU, Mr. Howard Simon, declared that these regulations ought to be made by the state legislatures. In practice, this would mean that all 50 legislatures would have to go through the long and laborious process of establishing these regulations, which would be acceptable to the court (assuming this to be possible). How long would it take? How many people might die in the meantime? What does ACLU propose to do to protect their rights? Ask the courts to bring them back to life?

One lawyer we know defended the ACLU failure to propose regulations on assisted suicide in its suit, arguing this was impossible to do in a constitutional case. This strikes us as the strongest argument for not making it a constitutional issue, in which the courts determine this on the basis of an abstract principle that can maintain the rights of the small group that wishes to die, at the expense of the vastly more numerous group who want to live. It suggests that the issue ought to be settled through the give and take of the legislative process, where all citizens can be involved and the burden of proof would be on those who want this participation in active killing.

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Jack Kevorkian opposes any legal regulation of assisted suicide. He argues this ought to be handled by the medical profession, acting as a professional guild system or a group of Platonic philosopher kings.

Kevorkian said flatly, "We don't need any laws to tell us how to do it (assisted suicide)."

He urged doctors to "sit down and lay out the rules by which you will operate and you will change them every week as you learn more."

Sadly some of the strongest expressions of prejudice against those with handicaps have come from the medical profession.

- In the 1979 issue of the medical journal, *Zeitschrift Fur Kinderchirurgie Und Grenzgebiete*, (page 301-305), three federally funded researchers -- Suzanne L. Feetham, Heather Tweed, and Jane S. Perrin -- wrote that medical centers in the U.S., Canada, and Great Britain had "selection policies" denying operations to infants with certain forms of spina bifida in the hope they would die.

- In 1984 an official of the Michigan Health Department, Dr. Richard Yerian, wrote that within the medical profession treating "malformed infants" was not seen as a basic part of medicine, but was considered a controversial "ethical issue" that had been "long discussed."

- In October, 1983, doctors from the University of Oklahoma Health Sciences Center wrote in *Pediatrics*, the official organ of the American Academy of Pediatrics, that they set up a criteria for determining which babies would be allowed to die, an algebraic formula for determining "quality of life" based on such characteristics as physical and mental capacities and family income. They rejected the principle that all human lives are created equal and adopted the doctrine that some lives were inferior quality, second class, Grade B, or C lives it was acceptable to destroy. Referring to the "Baby Doe" regulations proposed at the time, the doctors complained that if government got involved in protecting the lives of such babies, it would be impossible for hospitals to maintain such procedures. In short, they wanted law enforcement officials to look the other way, when it came time to protecting lives that failed their "quality" test. Kevorkian's proposal could be used to force the law to look the other way.

- Last year, distinguished journalist Nat Hentoff noted that the American Thoracic Society supported stopping life support treatments against the wishes of patients and their families, if their survival was not considered "meaningful."

- Hentoff also referred to a program on national public radio in which Dr. Michael Wilkes told of a study of approximately one thousand doctors in intensive care units in which the majority admitted to discontinuing or withholding life supports in opposition to the wishes of the patients and their families or without even informing them.

- Hentoff further cited the case of Giluun Vs. Massachusetts General Hospital in which he declared a local court ruled that a hospital and its physicians have a right to follow such policies. Hentoff

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emphasized that this verdict has "little significance in law", because it has not been accepted by a higher court. However, he emphasized, the case is under appeal and it may become a legal doctrine that doctors have the right to let patients die, if they consider their lives meaningless.

In this context, statements from two judges, which were favorable to Kevorkian, seem very ominous indeed.

Judge Cynthia Stephens declared she saw no difference between passive euthanasia and active euthanasia, between someone withdrawing a respirator or feeding tube and putting a bullet through his head. Unfortunately, in referring to the Nancy Cruzan Case and the Kevorkian Case, she was not really talking about what individuals were allowed to do to themselves but what third parties were allowed to do to them, on the basis that they wanted it. It was third parties that removed Nancy Cruzan's feeding tube, based on hearsay evidence as to what she wanted, years before she was faced with this condition. It would be third parties who might give patients lethal injections, or in her own words, put a bullet through their heads. It is significant that in passive euthanasia itself, the courts have given the lives of those with handicaps less safeguards than the lives of murder suspects. The Michigan Supreme Court has ruled that those who wish to deprive patients of treatment necessary for survival do not have to prove the patient's wishes beyond a reasonable doubt, but only "clear and convincing proof." Might this be true of assisted suicide? If the Gilun Vs. Massachusetts General Hospital verdict is approved by the Supreme Court, will doctors have the right to actively kill those they consider meaningless without their consent? If Kevorkian succeeds in letting the medical profession control assisted suicide, will those who imposed "selection policies" or withdrawal of treatment be able to worm their way onto medical boards that set the procedures for assisted suicide, and, in Kevorkian's words, change them every week.

Another disturbing view was expressed by Wayne County Circuit Judge Richard Kaufman. In his own pro Kevorkian verdict, Judge Kaufman declared that suicide was "reasonable" when a medical condition impairs a person's "quality of life." In effect, Judge Kaufman wished to put the doctrine raised by the Oklahoma center that those with handicaps have inferior quality lives into our legal system.

Fortunately, the Michigan Supreme Court overturned both the Stephens and the Kaufman legal philosophies. Unfortunately, after some rulings by other courts, these philosophies may in typical vampiric fashion rise up from the dead.

This would surely be the loathsome opposite of what our founding fathers intended, when they drafted the constitution and our Bill of Rights. The framers were clearly influenced by the values of the Declaration of Independence -- influenced enough to dedicate their lives, fortunes, and sacred honor for its principles. In creating a new government, they clearly sought to build a political framework based on the Declaration of Independence.

The Declaration of Independence declares that all men are created equal. The first right it lists is the right to live. It declares that to protect such rights, governments were established, making it unmistakably clear that governments that do not protect life are not

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doing their job. As if to make this unmistakable, a later generation passed a resolution assuring equal protection of the law. Our democratic system of law can not recognize the idea of inferior quality, Grade B, meaningless lives, any more than we can mix oil and water.

Without this tacit assumption that government has the responsibility to protect lives, none of the other provisions of the constitution have any meaning and none of these rights can be exercised (at least on this earthly plane). Of what use would it be to allow freedom of speech and press, if the law allowed lynch mobs free to hang those who disagreed with them? Of what use would it be to allow freedom of religion, if the law did not prevent religious fanatics from burning those they considered infidels?

Let us not impose on our country constitutional doctrines that weaken or sabotage the right to live.

This is our statement for the hearing. We intend to send you further material through the mail.



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VIRGINIA TROTTER BATES, JD, MSN, RN
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WRITTEN TESTIMONY
of the
AMERICAN NURSES ASSOCIATION
before the
**U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON THE CONSTITUTION**
**Oversight Hearing
“Assisted Suicide in the United States”**

Submitted May 1996

OVERVIEW

The American Nurses Association (ANA) is pleased to present testimony to the Subcommittee on the Constitution of the U.S. House of Representatives Judiciary Committee. ANA is a full-service national professional organization which represents this country's 2.2 million registered nurses throughout its 53 constituent state nurses associations. The ANA is deeply concerned about the issue of assisted suicide and the impact of the possible legalization of such acts on the care of the dying and the ethical norms of the profession.

Questions, controversies and debate over the issue of assisted suicide have become widespread within society and the health care community. In spite of a seemingly contemporary American view that death is the enemy, there is an increasing willingness to precipitate death to avoid what is frequently perceived and experienced as a frightening, painful, lonely and prolonged dying process. Burgeoning state legislative initiatives, media attention, public polls and a fascination with Dr. Jack Kevorkian reflect a growing trend within society. There is a broad spectrum of societal opinion as well as much philosophical, legal and religious debate surrounding these issues. The two recent U.S. court of appeals decisions in Washington and New York striking down as unconstitutional laws banning physician-assisted suicide propel this issue to a new level of importance and urgency.

The so called "right to die" movement with its basic assertion of a right to determine the time and manner of death serves as a "wake up call" to health care providers. It represents not only a claim to self-determination, but a response to the egregious shortcomings in the care of the dying. It has become clear that the tremendous advances in medical technology have not necessarily provided for human dignity, personal control or quality of life. The issue of assisted suicide has highlighted the deficits in care of the dying and focused attention on the obligation of health care professionals to provide responsible, respectful, appropriate and ethically sound care.

Nurses have traditionally been the health care professionals who have attempted to bridge the dichotomy between aggressive treatment interventions and the holistic, compassionate care of those who can no longer benefit from such an approach. There is a profound awareness of the devastation of life threatening illness and the

limits of technologic interventions. Nurses often feel caught in the middle between medical directives that appear unjustifiably burdensome and painful for patients and a desire to protect and advocate for patients. Of all health care disciplines, nursing is most attuned to the goals of palliative care and throughout the decades have been the mainstay of care for persons and their families at the end of life. Unfortunately, bureaucratic health care systems which have medically dominated hierarchies mitigate against the nurse's ability to exercise independence, authority and leadership in the care of the dying.

It would be naive to suggest that a positive transformation in care of the dying would entirely eliminate the issue of assisted suicide within this country, but it may help clarify what's truly at issue and eradicate factors that prompt such a request. Attempting to address the present failings in the care of the dying with a quick fix like assisted suicide is the wrong response. Health care professionals and society at large needs to be vigilant and aggressive in rectifying what is wrong with end of life care and advocating for and ensuring what is desired. The imperative needs to be a reversal of the degradation of the last stages of life and a recommitment to care of the critically ill and dying. The goal of providing quality end of life care is a challenge to the very integrity of health care professionals - one which must be met.

While nurses may not be specifically mentioned in any of the proposed legislation or recent court decisions, the role of nurses needs to be considered. Nurses by virtue of their distinct relationships with patients and families, and the centrality of their role within health care cannot help but be confronted by and struggle with the complex and troubling questions related to assisted suicide. Nurses have invaluable experience and insight in caring for dying persons and their families that must inform the discussions around assisted suicide and advance an agenda to improve the care of the dying.

Undoubtedly, nurses have been and will continue to be involved with patients who consider, request or choose assisted suicide as the manner in which to end their lives. If assisted suicide were to become legalized, physicians will not be the only health care professionals impacted. There are numerous aspects of patient care that could conceivably include nurses such as assessing the patient's decisional capacity and psychological state, discussing the option of assisted suicide with patients and families, evaluating the integrity of the informed consent process, witnessing a formal request for assisted suicide and remaining present when a patient chooses

assisted suicide. It is important to contemplate in advance how nurses might be called upon to fulfill the mandates of assisted suicide legislation and delineate the boundaries of professional practice. Thus it is imperative that nurses engage in professional and public dialogue about these issues and articulate the values and ethical precepts that shape the profession.

The American Nurses Association developed a *Position Statement on Assisted Suicide* in 1994 which provides clarification of the issue of assisted suicide, consideration of the role of nurses in end of life care and ethical guidance for practice (Attachment I). The position statement asserts the belief that nurses should not participate in assisted suicide, defined as “making a means of suicide available to a patient with knowledge of the patient’s intention and the patient subsequently acts to end his or her own life.” The statement affirms the indispensable role of nurses in the delivery of appropriate care at the end of life and their primary obligation to provide competent and supportive interventions. It is clear that the prohibition against participation in assisted suicide should not result in abandonment of patients.

The nursing profession’s stance is grounded in the ethical traditions and norms of the profession. Throughout the position statement nurses are urged not to confuse assisted suicide with ethically justified end of life decisions, to seek to understand the meaning of a request for assisted suicide, and to pursue opportunities to demonstrate their lasting commitment to patients and families. It is recognized that a nurse’s willingness to consider participation in assisted suicide is generally motivated by mercy, compassion, and promotion of patient autonomy. While no professional position can address all of the complex realities of clinical practice and professional life it does provide initial guidance for nurses as they consider these issues and an invitation to engage in ongoing professional discernment.

CONCLUSION

The American Nurses Association is deeply concerned about the quality of care rendered at the end of life and remains firmly committed to improving that care. As the largest group of health professionals and as those most connected with the comprehensive needs of the terminally ill and their families, nurses can provide the leadership and expertise needed to improve the care of the dying. Contemporary trends toward the legalization of assisted suicide challenge the traditional norms and fundamental attributes of the nursing profession.

The call for the legalization of assisted suicide represents the failure of society and the health care community to adequately meet the needs of dying persons and their families. Tragically, assisted suicide has been championed as the only way to escape the anticipated degradation of dying in the present health care system. However compassionate the motives behind assisted suicide initiatives, the risks and harms for patients, health professionals and the public are to great. Such initiatives may ultimately undermine efforts to improve care at the end of life and lead to intolerable abuses. The moral and professional challenge should not revolve around assisted suicide, but should be directed at fulfilling the obligation to provide competent, compassionate and committed end of life care.

Nurses, on behalf of the patients entrusted to their care, are advocating for the delivery of dignified and humane care at the end of life. For nursing professionals, the goals espoused in palliative care are fundamentally consistent with the valued aims of the profession. Nurses have embraced the obligation to provide relief of suffering, comfort, companionship and when possible a death that is congruent with the values and desires of the dying person.

The ANA and nursing community remains steadfast in its desire to improve the care of the terminally ill and believes that the accrued experience and expertise of nurses is essential to advancing such an initiative. Nurses need to remain in the forefront as leaders in the care of the dying .

AMERICAN NURSES ASSOCIATION

Position Statement
on

ASSISTED SUICIDE



SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the *Code for Nurses with Interpretive Statements (Code for Nurses)* and the ethical traditions of the profession. Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments.

There is a continuum of end-of-life choices that encompasses a broad spectrum of interventions from the alleviation of suffering, adequate pain control, do-not-resuscitate orders, withdrawing/withholding artificially provided nutrition and hydration, to requests for assisted suicide, and active euthanasia. Throughout this continuum nurses can respond to patients with compassion, faithfulness and support. Yet, nurses must understand the subtleties and distinctions of these issues in order to respond in a reasoned and ethically permissible manner.

TERMINOLOGY

In discussion of any controversial issue, one set of problems arises over definitions. Nurses and others interpret terms in vastly different and perhaps contradictory fashion. Thus clarification of language is essential. The first important distinction to make is that there are some end-of-life decisions that are fully consistent with the *Code for Nurses* and others that are not.

Assisted Suicide:

Suicide is traditionally understood as the act of taking one's own life. Participation in assisted suicide entails making a means of suicide (e.g., providing pills or a weapon) available to a patient with knowledge of the patient's intention. The patient who is physically capable of suicide, subsequently acts to end his or her own life. Assisted suicide is distinguished from active euthanasia. In assisted suicide, someone makes the means of death available, but does not act as the direct agent of death.

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Withholding, Withdrawing and Refusal of Treatment:

Honoring the refusal of treatments that a patient does not desire, that are disproportionately burdensome to the patient, or that will not benefit the patient can be ethically and legally permissible. Within this context, withholding or withdrawing life-sustaining therapies or risking the hastening of death through treatments aimed at alleviating suffering and/or controlling symptoms are ethically acceptable and do not constitute assisted suicide. There is no ethical or legal distinction between withholding or withdrawing treatments, though the latter may create more emotional distress for the nurse and others involved.

BACKGROUND

Among the most controversial, vigorously debated and, at times, confusing issues within contemporary society is assisted suicide. The nursing profession is also struggling with the complex moral and professional questions surrounding this issue. Scientific and technological advances have made it possible to extend life and prolong the dying process. These advances have not necessarily provided for the enhancement of human dignity, personal control or improvement in care.

Nurses witness firsthand the devastating effects of debilitating and life-threatening disease and are often confronted with the despair and exhaustion of patients and families. At times, it may be difficult to find a balance between the preservation of life and the facilitation of a dignified death. Nurses need to recognize their own feelings of sadness, fear, discouragement and helplessness and realize the influence of these feelings on clinical decision making. These agonizing tensions may cause a nurse to consider intentionally hastening a patient's death as a humane and compassionate response, yet the traditional goals and values of the profession mitigate against it.

The *ANA Code for Nurses with Interpretive Statements (Code for Nurses)* explicates the values and ethical precepts of the profession and provides guidance for conduct and relationships in carrying out nursing actions. It is within the framework of the *Code for Nurses* and professional standards that nurses make ethical decisions and discharge their responsibilities. The central axiom that directs the profession is respect for persons. This respect extends to and encompasses patients, families, nurse colleagues and team members. The principles of autonomy (self-determination), beneficence (doing good), nonmaleficence (avoiding harm), veracity (truth-telling), confidentiality (respecting privileged information), fidelity (keeping promises) and justice (treating people fairly) are all understood in the context of the overarching commitment to respect for persons. Nurses are challenged to uphold these principles as they confront the realities of professional practice.

Historically, the role of the nurse has been to promote, preserve and protect human life. The *Code for Nurses* states that respect for persons "extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering and the provision of supportive care of the dying. The nurse does not act deliberately to terminate the life of any person."

The profession of nursing is dominated by an ethic of care, an ideal that permeates and underscores all of nursing practice. The essence of caring takes place in the context of the nurse-patient relationship, the respectful and genuine presence of one human being to another. The perspective of care is a crucial and valuable dimension of ethical deliberation. From the perspective of care, nurses appreciate the emotional and contextual dimensions of ethical discernment. The uniqueness of individuals and the particular dynamics of relationships are recognized as integral components of the discernment process. The nurse's caring approach assists patients and families in finding meaning or purpose in their living and dying and furthers the attainment of a meaningful life and death.

RATIONALE:

- ◆ The profession's response to nurse participation in assisted suicide is grounded in the ethical traditions and goals of the profession, and in its covenant with society.
 - ◆ The profession of nursing is built upon the Hippocratic tradition "do no harm" and an ethic of moral opposition to killing another human being. The ethical framework of the profession as articulated through the *Code for Nurses* explicitly prohibits deliberately terminating the life of any human being.
 - ◆ Nursing has a social contract with society that is based on trust and therefore patients must be able to trust that nurses will not actively take human life. The profession's covenant is to respect and protect human life. (*Nursing: A Social Policy Statement*) Nurse participation in assisted suicide is incongruent with the accepted norms and fundamental attributes of the profession.
 - ◆ Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it.
- ◆ Acceptance of assisted suicide practices has the potential for serious societal and professional consequences and abuses.
 - ◆ While there may be individual patient cases that are compelling, there is high potential for abuses with assisted suicide, particularly with vulnerable populations such as the elderly, poor and disabled. These conceivable abuses are even more probable in a time of declining resources. The availability of assisted suicide could foreseeably weaken the goal of providing quality care for the dying.
 - ◆ Nurses must examine these issues not only from the perspective of the individual patient, but from the societal and professional community perspective.

Involvement in community dialogue and deliberation will allow nurses to recommend and uphold initiatives, and provide leadership in promoting optimal end-of-life care.

DISCUSSION:

♦ Assisted suicide is not to be confused with ethically justified end-of-life decisions and actions.

♦ The moral objection to the nurse's participation in assisted suicide does not diminish the nurse's obligation to provide appropriate interventions throughout the process of dying. Nurses must be vigilant advocates for humane and dignified care, for the alleviation of suffering and for the non-abandonment of patients.

♦ The withholding or withdrawal of life-sustaining treatment such as mechanical ventilation, cardiopulmonary resuscitation, chemotherapy, antibiotics and artificially provided nutrition and hydration can be ethically acceptable. Patients have the right to exercise their decisional authority relative to health care decisions, including foregoing life-sustaining treatments.

♦ The provision of medications with the intent to promote comfort and relieve suffering is not to be confused with the administration of medication with the intent to end the patient's life. "The nurse may provide interventions to relieve symptoms in the dying client even when the interventions entail substantial risks of hastening death." (*Code for Nurses*)

♦ Nurses should seek to understand the meaning of the request for assisted suicide and continue to demonstrate respect for and commitment to patients.

♦ It is not uncommon for patients to think about suicide during the course of illness. Requests for assisted suicide can be related to numerous factors including unrelieved pain and other symptoms, depression, feelings of loss of control, fear of isolation, concern for family and a sense of hopelessness. Nurses should avoid judgement of patients or their experience and recognize that only the suffering person can define that suffering.

♦ There are positive obligations to ascertain the patient's concerns, fears, needs and values, to discuss health care options and to provide counsel and support. Discussion of suicidal thoughts does not increase the risk of suicide and may actually be therapeutic in decreasing the likelihood. The relationship and communication between the nurse and patient can diminish feelings of isolation and provide needed support.

♦ Nurses have an opportunity to create environments where patients feel comfortable to express thoughts, feelings, conflict and despair. The issues that surround a request for assisted suicide should be explored with the patient, and

as appropriate with family and team members. It is crucial to listen to and acknowledge the expressions of suffering, hopelessness and sadness. When possible, factors that contribute to such a request should be alleviated, and existing patient strengths and resources promoted and relied on.

- ◆ Nurses must identify and seek opportunities to demonstrate their lasting commitment to patients and families within the confines of professional practice. Efforts should be directed at the implementation of programs of palliative care to better manage chronic, severe bio-psycho-social and spiritual distress that limit quality of life and increase suffering.

- ◆ Nurses are obligated to listen compassionately to patients' requests, but must recognize the boundaries of acceptable ethical practice. Nurses can be honest with patients and acknowledge that they can not participate in assisted suicide, yet still manifest a commitment to non-abandonment.

- ◆ Acknowledging the prohibition against participation in assisted suicide does not necessarily lessen the distress and conflict a nurse may feel when confronted with a patient's request.

- ◆ Nurses may encounter agonizing clinical situations and experience the personal and professional tension and ambiguity surrounding these decisions. The reality that all forms of human suffering and pain cannot necessarily be removed except through death is not adequate justification for professional sanctioning.

- ◆ Nurses need to be aware of their own sense of suffering, discomfort, confusion and inadequacy. Acknowledgement of caregiver struggle and vulnerability can connect nurses deeply with the experience of the patient and family.

- ◆ Nurses should seek the expertise and resources of others including nurse colleagues, team members, pastoral services, hospice specialists and ethics consultants/committees when confronting the complexity of these issues.

- ◆ The willingness to consider participation in assisted suicide is generally motivated by mercy, compassion, promotion of patient autonomy and quality of life considerations. It is recognized that the nurse's views about participation in assisted suicide may be different than the official position of the nursing profession. Regardless of the opinion of the nurse, it is a breach of the ethical traditions of nursing, and the *Code for Nurses*, to participate in assisted suicide.

RECOMMENDATIONS

- ◆ The debate and controversy surrounding assisted suicide has highlighted the shortcomings of the health care system, in particular, care of the dying. Nurses and the nursing profession can take an active stance to create health care environments that provide humane care.

- ♦ Advance the precepts of *Nursing's Agenda for Health Care Reform*, one of which calls for careful assessment of the "appropriateness of providing high-tech curative medical care to those who simply require comfort, relief from pain, supportive care or peaceful death."
- ♦ Engage in professional and public dialogue and decision making around assisted suicide. Encourage the participation of nurses in discussions of this issue at the local, state and national level.
- ♦ Collaborate with other members of the health professions and citizens to advance and ensure the availability of quality end-of-life care.
- ♦ Provide education for health professionals and the community on ethical and legal rights and responsibilities surrounding health care decision making, treatment options, pain control, symptom management and palliative care.
- ♦ Support the use of outcome measurements and further research to ensure more scientifically based, responsible and ethically sensitive end-of-life treatment.
- ♦ Advocate for the removal of barriers to the delivery of appropriate end-of-life care through legislation and changes in restrictive regulatory and institutional practices.
- ♦ Promote patient and family participation in treatment decision making and the use of advance directives.

CONCLUSION

Nurses need to remain in the forefront as leaders and advocates for the delivery of dignified and humane end-of-life care. Nurses are obliged to provide relief of suffering, comfort and when possible a death that is congruent with the values and desires of the dying person. Yet, nurses must uphold the ethical mandates of the profession and not participate in assisted suicide.

Knowledge of the ethical foundations and parameters of professional practice provides guidance and support to nurses both individually and collectively. Such an undertaking will better prepare nurses to deal with the difficult moral and professional challenges surrounding the issue of assisted suicide.

REFERENCES

- American Nurses Association (1992). *Nursing's Agenda for Health Care Reform*. Washington, D.C: The Author.
- American Nurses Association (1985). *Code for Nurses with Interpretive Statements*. Kansas City, MO: The Author.
- American Nurses Association (1980). *Nursing: A Social Policy Statement*. Kansas City, MO: The Author.
- American Nurses Association (1992). *Compendium of Position Statements on the Nurse's Role in End-of-Life Decisions*. Washington, DC: The Author.
- Brock, D. (1992). Voluntary Active Euthanasia. *Hastings Center Report*. 22(2): 10-22.
- Brody, H. (1993). Causing, Intending and Assisting Death. *The Journal of Clinical Ethics*. 4(2): 112-117.
- Coyle, N. (1992). The Euthanasia and Physician-Assisted Suicide Debate: Issues for Nursing. *Oncology Nursing Forum*. 91(7): 41-46.
- Freeman, E. (1992). Nurse-Assisted Suicide. *Journal of the Association of Nurses in AIDS Care*. 3(1): 23-24.
- Fowler, M. (1988). On Killing Patients. *Heart and Lung*. 17(3): 322-323.
- Jecker, N.S. (1991). Giving Death a Hand: When the Dying and the Doctor Stand in a Special Relationship. *Journal of the American Geriatrics Society*. 39(8): 831-835.
- Kowalski, S. (1993). Assisted Suicide: Where Do Nurses Draw the Line? *Nursing and Health Care*. 14(2): 70-75.
- Solomon, M.Z., et al. (1993). Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments. *American Journal of Public Health*. 83(1): 14-21.
- Smith, D.C. & Olsen, P. (1993). The Right to Choose Death. *The American Journal of Hospice and Palliative Care*. September-October:7-9.
- Young, A., et al. (1993). Oncology Nurses' Attitudes Regarding Voluntary, Physician Assisted Dying for Competent, Terminally Ill Patients. *Oncology Nursing Forum*. 20(3): 445-451.

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**STATEMENT OF THE COMMITTEE FOR PRO-LIFE ACTIVITIES
NATIONAL CONFERENCE OF CATHOLIC BISHOPS**

The Catholic Church's opposition to euthanasia and assisted suicide is well known, and is as old as Christianity itself. The early Church condemned both suicide and homicide as gravely wrong, despite acceptance of suicide in much of the surrounding pagan culture.¹ Moral teaching against assisting a suicide is actually older than Christianity, for it is found in Jewish tradition and in the Hippocratic Oath which laid the groundwork for modern medicine as a healing profession. This stance reflects a nearly universal consensus of our culture and law.

We believe that life is our first and most basic gift from a loving God -- a gift over which we are called to have careful stewardship, not absolute dominion. This stewardship demands that we take reasonable steps to preserve human life. It does not obligate us to use every possible treatment to prolong life, regardless of the circumstances -- but it does reject efforts to address the problems of the sick and dying by intentionally helping to cause their deaths. The Catholic bishops of the United States have reaffirmed their opposition to euthanasia and assisted suicide on many occasions, most recently in public reactions to rulings this year by the Ninth and Second Circuit Courts of Appeals [Attachment 1].

This is not only a religious and moral issue, but a human rights issue as well -- one that should be of urgent concern to Congress, and especially to this Judiciary Committee. Because the right to life is the condition for our exercise of all other rights, a law or court ruling which undermines this basic right for any class of the human family denies "the equality of everyone

¹This fact deserves restating because a recent ruling by the Ninth Circuit Court of Appeals so thoroughly mangles the historical record. For a responsible account of the early Church's opposition to suicide and euthanasia see Darrel W. Amundsen, "Suicide and Early Christian Values," in *Medicine, Society, and Faith in the Ancient and Medieval Worlds* (Johns Hopkins University Press 1996), pp. 70-126. Also see Thomas J. Marzen, "Assisted suicide: Back to the (pagan) future," *Our Sunday Visitor*, 4/14/96, pp. 6-7.

before the law."²

Many specific federal laws are implicated by new developments on assisted suicide [Attachment 2]. In this testimony, however, we wish to emphasize how basic questions about equality under the law are raised by recent efforts to legalize euthanasia and assisted suicide.³

Freedom or Discrimination?

Supporters claim that assisted suicide is about promoting "freedom of choice" and relieving suffering among those who want to end their lives. Yet people who may want to commit suicide are found in every demographic group -- especially among the young, the very old and members of certain high-stress professions. From the viewpoint of suicidal persons in any such group, their pain and suffering is more real and more intolerable than any physical pain that could be relieved by morphine and other pain-killers. Persistent suicidal desires among the terminally ill are not significantly more common, are no more "free," and no less caused by treatable depression than such desires felt by people in these other groups.⁴ Yet an entire legal

²Pope John Paul II, Encyclical Letter *Evangelium Vitae* (*The Gospel of Life*), §72.

³While some seek to distinguish assisted suicide (prescribing of lethal drugs for self-administration by a patient) and active euthanasia (administration of lethal drugs by a physician), both involve physicians in directly and intentionally helping to cause death. The recent ruling by the Ninth Circuit Court of Appeals found no "principled distinction" between the two. In fact, Hemlock Society founder Derek Humphry notes that "about 25% of assisted suicides fail," creating increased suffering and a lingering dying process that physicians may feel obliged to resolve through lethal injection. "The new Oregon way to die will only work," he writes, "if in every instance a doctor is standing by to administer the *coup de grâce* if necessary" (Letter to the Editors, *New York Times*, 12/3/94, p. 22). As the president of the Nebraska Hemlock Society has said: "When you strip away all the euphemisms, we're talking about doctors killing patients" (Carl Schmitthausler, quoted in *Lincoln Journal Star*, 12/30/95, p. 7A).

⁴In one recent study of 199 patients with advanced terminal cancer, only 9% exhibited "an apparently sincere and sustained wish to die"; 59% of this group had traditional symptoms of clinical depression. When six of these patients were re-interviewed two weeks later, the wish for

and political movement has dedicated itself to facilitating suicide for the seriously ill, even while the law continues to forbid such "assistance" for everyone else.

Why would the State continue to view assisting the suicide of anyone else as a homicide, but view assisting the suicide of certain seriously ill or disabled people as a decent and lawful act? The only possible answer is: Because the State has made its own supposedly "objective" judgment that these patients, unlike any other citizens, have lives not worth protecting. When these particular people think they have lives not worth living, government can think of no reason to disagree.

Imagine the scenario: Two people come forward wanting to commit suicide. Both have made a suicidal decision that they see as free and rational; both say they find nothing but pain and suffering in continuing with life. But one is able-bodied, while the other has an illness or disability that two physicians say is "terminal." On this basis, a law like the one recently approved in Oregon says to the first person that his life is too valuable to throw away -- that we will provide counseling and psychological assistance to relieve these suicidal feelings, and legally forbid anyone to provide "aid" in suicide. To the second person the State will say: "Go right ahead. In fact we've anticipated your request, by proclaiming in advance that we have no interest in preventing the suicide of someone with your condition. Officially the government doesn't care whether you live or die. Bon voyage."

This is not a recipe for greater freedom. It gives to government a new power that no human being should have: The power to decide which citizens' lives will be protected by law, and

death had greatly declined in four. The only patient who ever explicitly asked for euthanasia met the criteria for major depression and had a history of three earlier depressive episodes. Chochinov et al., "Desire for Death in the Terminally Ill," *Am. J. of Psychiatry*, August 1995, pp. 1185-91.

which will not.⁵ As one columnist has put it very succinctly, this is "death with a note from Big Brother."⁶

Anyone who thinks this overstates the situation should read the recent rulings by the Ninth and Second Circuit Courts of Appeals. For example, the Ninth Circuit decision declares that "the state has a legitimate interest in preventing suicides in general,"⁷ and that "suicide by teenagers and young adults is especially tragic."⁸ But the court finds that government has little interest in preventing suicide among the sick who cannot be restored to "a state of physical and mental well-being."⁹

Finding "compelling similarities" between this issue and that of abortion, the court compares the life of the frail and elderly with the supposedly merely "potential" life destroyed in abortion: When balancing an individual's desire for suicide against the state's interest in protecting life, "the outcome of the balancing test may differ at different points along the life cycle as a person's physical or medical condition deteriorates, just as in abortion cases the permissibility of

⁵ "The height of arbitrariness and injustice is reached when certain people such as physicians or legislators arrogate to themselves the power to decide who ought to live and who ought to die." *Evangelium Vitae*, op. cit., §66.

⁶Debra J. Saunders, "Death With a Note From Big Brother," *The San Francisco Chronicle*, 8/31/92, p. A18.

⁷*Compassion in Dying v. Washington*, No. 94-35534 (9th Cir. March 6, 1996), *to be reported at* 79 F.3d 790; slip op. at 3178.

⁸*Id.* at 3177.

⁹*Id.* at 3178. The court's ruling is not limited to those ordinarily seen as "terminally ill." It includes patients in a coma or "persistent vegetative state," and permanently disabled people who could live a long time with continued treatment but would die soon without it. *Id.* at 3200.

restrictive state legislation may vary with the progression of the pregnancy."¹⁰

The Second Circuit ruling is equally blunt in this regard. Its decision makes no pretense of defending a "fundamental right or liberty" to assisted suicide, for it finds no basis for such a right.¹¹ Its decision is based on the belief that preventing suicide among the terminally ill, unlike preventing suicide among other citizens, is "not rationally related to any legitimate state interest" due to "the greatly reduced interest of the state in preserving life" for such patients.¹² "Surely," says the court, "the state's interest lessens as the potential for life diminishes"¹³ -- reminding us again of *Roe v. Wade*'s theories on "potential life," and its sliding scale of legal protection based on the fetus's "potential for meaningful life" outside the womb.

Some groups have hailed these two rulings as victories for civil liberties, comparing them to past court rulings affirming women's "liberty" to have an abortion. But in these new extensions of *Roe v. Wade*'s logic, terminally ill patients are not primarily treated like the pregnant woman -- they are treated the way *Roe* treats the unborn.

Clearly, judges and others who support such legal developments do not think they are practicing invidious discrimination against people with serious illnesses and disabilities. They believe they are giving these people a new "right" to end their lives painlessly. Yet they say they are not interested in granting this "right" to able-bodied people like themselves. If a law gave

¹⁰ Id. at 3132. While the court speaks of the sick individual as a "person," in terms of the protection of life it compares that individual to beings denied the status of "person" in current abortion policy.

¹¹ *Quill v. Vacco*, No. 95-7028 (2d Cir. April 2, 1996), slip op. at 17-19.

¹² Id. at 36, 32.

¹³ Id. at 31.

such selective "freedom" for assisted suicide to other defined classes of people -- solely to women, or to African Americans, or to members of a certain religion -- howls of protest would rise up from civil rights organizations, and rightly so. The fact that many people do not see such invidious discrimination in the assisted-suicide agenda is an indication of how deep some of our prejudices about frail or seriously ill people really are. Physically healthy people simply assume that in some objective sense they are indeed "better off dead," that their suicides are rational and legitimate when other people's suicides are not.

In fact this prejudice is directly contrary to the views of those with the most experience of serious illness or old age. Senior citizens are far more opposed to assisted suicide than younger voters¹⁴. Moreover, physicians who have treated many terminally ill patients are more opposed to it than those without such experience.¹⁵

In our view, U.S. District Court judge Michael Hogan was absolutely correct when he found that Oregon's law allowing assisted suicide violates the Equal Protection clause of the U.S.

¹⁴Even polls by the Hemlock Society show that "the younger the person, the more likely he or she is to favor this legislation" allowing assisted suicide (*Hemlock TimeLines*, Jan.-Feb. 1994, p. 9). A recent national survey by the *Washington Post* showed 50% support for making physician-assisted suicide legal (*Washington Post*, 4/4/96, p. A18); but support dropped to 38% among those aged 65 or over. A July 1995 poll by The Tarrance Group found that "voters aged 18 to 34 years old support assisted suicide, 56% to 40%. But those aged 65 and over -- who some would see as the primary beneficiaries of a legal 'right to die' -- oppose the practice 55% to 37%, with 48% strongly opposed" ("Poll: Americans Divided on Euthanasia," *Life at Risk: A Chronicle of Euthanasia Trends in America*, June/July 1995, p. 1).

¹⁵In a recent survey of Michigan physicians, legalization was favored by 73% of those who "never" treat terminally ill patients but by only 44% of those who treat them "very often" (J. Bachman et al., "Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia," *New England J. of Medicine*, 2/1/96, p. 306. The same correlation is found among Washington physicians: J. Cohen et al., "Attitudes toward assisted suicide and euthanasia among physicians in Washington State," *New England J. Of Medicine*, 7/14/94, p. 93.

Constitution. As Judge Hogan said:

Measure 16 withholds from terminally ill citizens the same protections from suicide the majority enjoys. In the process, it has lowered standards and reduced protections to a degree that there is little assurance that only competent terminally ill persons will voluntarily die. The majority has not accepted this situation for themselves, and there is no rational basis for imposing it on the terminally ill.¹⁶

Some people think the exploitation of vulnerable patients under a regime of legalized assisted suicide can be prevented by incorporating various "safeguards" into the law. In fact, the Ninth Circuit's new ruling renders some of that question moot, by indicating that some widely supported "safeguards" may well be found unconstitutional once the courts view assisted suicide as a fundamental right.¹⁷ In any event, calls for safeguards miss the point. Any law that singles out a class of citizens for disparate treatment under the law of homicide perpetrates the same basic injustice. Once that unjust decision has been made, efforts to "fix" the law by tightening its loopholes only have the effect of defining ever more clearly the isolated class of patients to be singled out for exclusion from the law's protection. Such an unfair law cannot be "fixed." Government will still be making a preemptive judgment that citizens of a certain description -- the vast majority of whom have never expressed any desire to die -- are good candidates for a

¹⁶*Lee v. Oregon*, 891 F.Supp. 1429 (D. Or. 1995) at 1438.

¹⁷The court refuses to find that "safeguards" like those in the Oregon law are "either necessary or desirable"; states may decide "which, if any, to adopt." *Compassion in Dying*, op. cit., fn 123 at 3204. In fact, as in past abortion rulings, states are *not allowed* to place too great a burden on the right to a quick and painless death: A waiting period to give patients time to think over the decision must be "short" (Id. at 3204), and a law requiring family or loved ones to be consulted and concur in the decision "would raise constitutional concerns" (Id., fn 100 at 3192).

premature death by lethal drugs.

No Alternative?

Despite these problems, some Americans think that the drive to legalize physician-assisted suicide will inevitably prevail -- both because this agenda is politically popular, and because our society has no alternative solution to the problems of the terminally ill. These assumptions, too, are false.

To speak first of the political situation: Thirty-four states have explicit statutes against assisted suicide, and almost all the others ban the practice under the common law or by judicial interpretation of the state homicide law.¹⁸ By popular referendum, the voters of Washington and California in recent years have rejected efforts to legalize physician-assisted suicide for the terminally ill -- although these states were chosen by euthanasia supporters as ideal battlegrounds. The voters of only one state, Oregon, have approved a law allowing physician-assisted suicide, by the narrow margin of 51 to 49 percent; that law has been found unconstitutional by a U.S. District Court, whose judgment is on appeal. In the past year, the legislatures of thirteen states have considered bills like Oregon's and soundly rejected all of them [Attachment 3]. Moreover, states continue to enact new laws *against* assisted suicide; the most recent such law was signed by the governor of Iowa on March 1. While some polls use vague questions to suggest broad support for "aid in dying" or "death with dignity," the people and their

¹⁸See: Americans United for Life, *Legal Status of Assisted Suicide: Legislation Guide* (Chicago: August 1995); *Iowa Catholic Conference Newsletter*, 3/4/96, p. 1.

elected representatives have spoken many times on this issue -- and once they understand what is being proposed, they oppose legalizing assisted suicide. It is because they are losing so regularly in the democratic segments of our government that supporters of assisted suicide have turned to the courts.

Finally, there are alternative solutions to the problems which assisted suicide purports to solve. What Pope John Paul II calls "the way of love and true mercy"¹⁹ -- easing suffering, keeping company with dying patients, and affirming the dignity of their lives at every stage -- is the most complete response to efforts to promote death as a solution. Few dying patients express any suicidal wishes once they receive the kind of excellent supportive care that can be found in modern hospices.²⁰ Great advances have been made in pain management, so that "no one need be in serious pain" while dying -- though far more physicians need to become familiar with these advances.²¹ In fact, dying patients are distressed by problems other than the experience of physical pain -- by "fear of pain, loss of control, indignity, and being a burden to their families" -- but "good supportive care for patient and family could ameliorate all of these."²²

¹⁹*Evangelium Vitae*, op. cit., §67.

²⁰Council on Scientific Affairs, American Medical Association, "Good Care of the Dying Patient," *Journal of the American Medical Association*, 2/14/96, p. 476.

²¹Id., p. 475. Says the ethics chairman of the Academy of Hospice Physicians: "As a doctor who has been involved in hospice care for more than 14 years, I can state without equivocation that the physical sources of suffering associated with dying all can be controlled." Ira Byock, "Kevorkian: Right Problem, Wrong Solution," *The Washington Post*, 1/17/94, p. A23.

²²AMA Council, op. cit., p. 475.

There has been far too little attention to the ways in which social acceptance of assisted suicide can *increase* the suffering of dying patients. For example, a major source of their suffering is the loneliness and isolation they often feel in modern hospitals. Doctors tend to avoid these patients -- partly because they are a reminder of the doctor's failure to cure, and partly because doctors, being only human, do not want to get too attached to someone who will die soon. How much more distant will doctors become when they must see every terminally ill patient as someone they might be asked to kill soon? And how much more will that distancing increase the isolation, loneliness and despair of patients who need human companionship and moral support above anything else?

In short, there are life-affirming solutions for the suffering of seriously ill patients. Access to these solutions should be improved, especially for the poor who so often lack access even to basic health care. By contrast, assisted suicide and euthanasia do not eliminate suffering -- they eliminate the patient. The suffering remains, to be felt by the next patient with the same condition who will feel subtle or overt pressure to ease the burden on others by making a timely exit.

In conclusion: Legalization of assisted suicide is a defeat for equal justice under law, not a victory for freedom. Laws protecting people from lethal attack -- including those protecting us from our own suicidal impulses -- must cover everyone equally. They must not single out certain classes of people for allowable killing, for to do so is inevitably to brand them as disposable people. Terminally ill citizens, like all the citizens of the United States, deserve better.

STATEMENT OF BURKE J. BALCH, J.D.**DIRECTOR, DEPARTMENT OF MEDICAL ETHICS****NATIONAL RIGHT TO LIFE COMMITTEE**

**Oversight Hearing on Assisting Suicide
House Judiciary Subcommittee on the Constitution
April 29, 1996**

The decisions of the Second and Ninth Circuits mandating legalized euthanasia create profound dangers for the most vulnerable amongst us. Unfortunately, these dangers have been obscured by a failure of most media accounts to report fully on the implications of these decisions, and attention has been diverted from them by inaccurate accounts of the current treatment of suicide and the rejection of treatment by the law. This testimony will seek to highlight those implications and correct those inaccuracies.

I. Nonvoluntary Euthanasia for People with Disabilities

Press accounts of the decisions of the two federal circuit courts of appeal have focused on their legalization of voluntary assisted suicide for those who are terminally ill. In fact, the opinions sweep far more broadly. The language of the Ninth Circuit opinion explicitly declares a right on the part of "surrogates" to choose lethal prescriptions for

patients incapable of making health care decisions themselves.

In the context of what it declared the right to get a lethal prescription, the court wrote, "[W]e should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." *Compassion in Dying v. State*, 1996 WL 94848 (9th Cir. Mar. 6, 1996), *83 fn. 120.

Under this, people with Alzheimer's disease, children with disabilities, and indeed anyone who is not legally "competent" to make health care decisions could be put to death on the decision of a guardian or other "surrogate."

While the decision of the Second Circuit was not as explicit, the consequences of its reasoning are similar. Essentially, the Second Circuit concluded that it is unconstitutional for any state to make a distinction between withholding of treatment, on the one hand, and providing an agent for direct killing, on the other hand. Laws that allow treatment withholding but prevent direct killing, it held, violate the Equal Protection Clause of the Fourteenth Amendment.¹

This means that in any state whose statutes or court decisions authorize surrogate decisionmaking for patients who have not left instructions or appointed a health care agent with respect to decisions to reject treatment, under the Second Circuit's reasoning that will have the effect of allowing surrogates to authorize lethal prescriptions for incompetent patients who have never expressed a desire to be killed.

In the majority of states whose courts have confronted the issue, the ruling has

¹ A more detailed explanation of the Second Circuit opinion is provided in Appendix A to this testimony.

been, in the words of the Washington Supreme Court, that "An incompetent's right to refuse treatment should be equal to a competent's right to do so." *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 449 (1987), *modified*, 757 P.2d 534 (1988). To date, the courts of fourteen states have held that constitutional equal protection guarantees, or other constitutional provisions, require that guardians must be permitted to "substitute their judgment" for the unknown preference of the incompetent patient, and thus be able to opt to reject life-sustaining medical treatment.²

Many other states allow surrogates to reject life-saving medical treatment for incompetent patients whose wishes are unknown, either by statute or by state court decisions interpreting the common law.

Thus, legalization of assisting suicide must in fact result in the legalization of nonvoluntary active euthanasia.

II. THERE IS A RATIONAL BASIS FOR STATES' DISTINGUISHING BETWEEN REFUSAL OF TREATMENT AND DIRECT KILLING

One of the most basic errors in the opinions of the Second and Ninth Circuits is central to their reasoning: the claim that there is no rational, constitutionally cognizable difference between the legal right to reject treatment, on the one hand, and assisting suicide or euthanasia, on the other.

The Ninth Circuit put it this way: it asserted that there is "no ethical or

² See Appendix B.

constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. ... To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other." *Compassion in Dying*, 1996 WL 94848 at *27. (For the Second Circuit's similar position, see Appendix A.)

The reality is more complex. Patients and their doctors must constantly make decisions among alternate courses of treatment, each with their own mix of risks of death and probabilities of benefit. Treatment A may have a 40% chance of long-term benefit, but a 50% chance of immediate death; treatment B may have a lesser 5% risk of immediate death, but only a 10% chance of preventing death in the long term. In some cases the probability of death from accepting--or rejecting--a particular course of treatment may be higher, but these probabilities are all along a continuum.

This reality is not limited to choices about medical treatment. Whenever you drive a car, cross the street, or go skiing, you choose a course of action that entails the *risk* of death. Even if you remain at home in bed with the covers drawn over you, you risk death: from lack of exercise, from starvation for failure to earn money for food, and even from dying in an earthquake that might strike. It is literally impossible to live and make choices that entail some risk of death. But when you drive on the highway to get to work, knowing there is the danger of an accident, are you intending to die? Is your action the ethical equivalent of suicide?

Of course not, but that is where Judge Reinhardt's reasoning leads.

Is it possible for a given patient and doctor in a particular situation to *intend* to

bring about the patient's death by rejecting treatment? Certainly, and if there is such a deliberate omission with the intent to cause death, that conscious rejection of treatment is the ethical equivalent of suicide. But for every such case there are many more instances in which treatment is rejected with an intent other than that of bringing about death--perhaps as a result of balancing risks of death against probabilities of benefit.

Now for the key point: how could the state in practice separate out treatment decisions that involved suicidal intent from those that did not? It would have to institute an utterly impractical and tyrannical inquisitorial process, somehow subjecting all or a large class of treatment decisions that involve a risk of death to review designed to tease out the actual intent of the decisionmakers in each case.

Because such a governmental process is unimaginable, it is entirely rational for the state to draw a line under which the state does not interfere with patient's decisions to accept or reject treatment except in very unusual circumstances, but prevents doctors and others from directly causing death by lethal doses of drugs or the like. By definition, there is a clear intent to cause death in the latter circumstances.

The failure of the two circuits to recognize these key distinctions is essential to their extremist holdings. The inevitable consequence of their mistaken lumping together of decisions about accepting or rejecting treatment with direct killing is dramatic: At present, competent people or the surrogates of incompetent people can reject treatment under essentially any circumstances. Indeed, it is generally battery to impose treatment on anyone without informed consent; the one rejecting treatment need give no reasons. If killing someone is treated as constitutionally equivalent to rejection of treatment, then

assisting suicide and even nonvoluntary euthanasia must essentially be permitted in equivalent circumstances, and the state has no more right to inquire into the reason for it than, under Roe v. Wade, it has to inquire into the reasons someone seeks an abortion.

III. DOES THE FACT THAT NO STATE NOW PUNISHES SUICIDE OR ATTEMPTED SUICIDE MAKE IT IRRATIONAL AND DISCRIMINATORY TO PUNISH ASSISTING SUICIDE?

Advocates of legalizing assisting suicide frequently argue thus: at present, there are no criminal penalties for anyone who commits or attempts to commit suicide. If the law does not penalize something, that means that people are free to do it; therefore, it is now legal to commit or attempt to commit suicide. That being the case, it is irrational and discriminatory to punish doctors or others who assist suicide. After all, the argument goes, there are those who are physically incapable of killing themselves without assistance; shouldn't they have an equal opportunity for suicide as those physically able who can now commit suicide with impunity?

This entire argument rests on a faulty premise: that people who are physically able to do so now have the "freedom" to commit suicide.

Why is this premise faulty? Let us begin by comparing the situation of someone who avails herself of First Amendment rights to denounce a politician in a public park. If an irate supporter of the politician tries physically to restrain the speaker and prevent

her from making her denunciations, that person will be subject to criminal charges of assault and battery. On the other hand, suppose someone else tries physically to restrain someone to prevent that person committing suicide. In the words of the Minnesota Supreme Court in a 1975 case, "[T]here can be no doubt that a bonafide attempt to prevent a suicide is not a crime in any jurisdiction, even where it involves the detention, against her will, of the person planning to kill herself."³

In fact, if public authorities detect someone in the act of attempting to commit suicide, they will typically not only interfere, but also place the person in the custody of mental health authorities--and posing a danger to oneself is a basis for involuntary commitment for mental health treatment.

In short, it is not accurate to say that at present people have the legal liberty to commit suicide, because they can be, and frequently are, legally restrained from doing so. But if suicide is not today treated as a freedom, why are there no criminal penalties against it?

For the answer to that it is desirable to review a little history.⁴ While it might seem self-evident that someone who completes a suicide cannot be punished (after all, he or she is dead) in fact, under the old English common law there *was* punishment of a sort: the suicide was buried "ignominiously" (at a crossroads, and perhaps even with a stake through the heart) and the personal property of the suicide was forfeited to the

³ State v. Hembd, 305 Minn. 120, 126, 232 N.W.2d 872, 878 (1975).

⁴ The historical account that follows is based on a law review I co-authored in 1985. Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone & Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 56-100 (1985).

state.

There were instances of ignominious burial and forfeiture in the American colonies. By the time of the American Revolution or shortly thereafter, however, these had been abolished in virtually all states. Yet this was not because early Americans approved of suicide. In an influential 1796 treatise, Zephaniah Swift, later Chief Justice of Connecticut, explained they were discontinued because it was seen as "contemptible" to exercise a "mean act of revenge upon lifeless clay, that is insensible of punishment" and cruel to inflict "a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender."⁵

Wrote Smith, "it is evident that where a person is so destitute of affection for his family ... as to wish to put an end to his existence, that he will not be deterred by a consideration of their future subsistence. Indeed, this crime is so abhorrent to the feelings of mankind, and that strong love of life which is implanted in the human heart, that it cannot be so frequently committed, as to become dangerous to society."⁶

Thus, ignominious burial and forfeiture were ended not because suicide had come to be seen as a liberty--as Swift's words evidence, it was severely reprobated--but because ignominious burial and forfeiture were seen as both useless and unjust to innocent family members.

Indeed, the colonies and states continued to punish assisting suicide, and even attempting suicide. Later, in the latter part of the Nineteenth and in the early Twentieth

⁵ 2 Zephaniah Swift, *A System of Laws of the State of Connecticut* 304 (n.p. 1795).

⁶ *Id.*

Centuries, penalties for attempting suicide were generally repealed--but not because suicide was seen as a liberty. Rather, the feeling grew that those who attempted suicide should be given treatment for mental disorders rather than punished. Typical was the 1902 statement of a Pennsylvania court about one who attempted suicide: "[I]t is the result of disease. He should be taken to a hospital and not sent to a prison."⁷ In 1980, the Supreme Court of Iowa wrote, "The only reason we view suicide [as] noncriminal is that we consider inappropriate punishing the suicide victim or attempted suicide victim, not that we are concerned about that person's life any less than others' lives. To say that aiding and abetting suicide is a defense to homicide would denigrate these views."⁸

Indeed, the virtually universal pre-1980 consensus of American jurisprudence is in fact best summarized by the 1933 words of the Florida Supreme Court: "No sophistry is tolerated ... which seek[s] to justify self-destruction as commendable or even a matter of personal right."⁹

⁷ *Commonwealth v. Wright*, 11 Pa. D. 144, 146 (1902).

⁸ *State v. Marti*, 290 N.W.2d 570, 581 (Iowa 1980).

⁹ *Blackwood v. Jones*, 111 Fla. 528, 532-33, 149 So. 600, 601 (1933). Our article, *supra* n. ?, spent pages and pages quoting court after court in the Nineteenth and Twentieth Centuries strongly condemning suicide. Not once did any pre-1980 court even suggest that laws preventing the assistance of suicide might be unconstitutional.

Although the Ninth Circuit disparaged reliance on history (it wrote, "[T]he fact that we have previously failed to acknowledge the existence of a particular liberty interest or even that we have previously prohibited its exercise is no barrier to recognizing its existence." *Compassion in Dying v. State*, 1996 WL 94848 (9th Cir. Mar. 6, 1996), *13), it did devote two paragraphs to the treatment of suicide in the history of American law.

Ironically, of the eight footnotes naming sources on which the court relied for those two paragraphs, six cited our 1985 article. Regrettably, the court's selective use of our historical research amounted to a misleading distortion of it. Even the scanty summary of that research in the text of this testimony largely rebuts and corrects the misleading impression given by the Ninth Circuit's two paragraphs. Two further points,

however, are worthy of clarification.

First, the Ninth Circuit stated, "By the time the Fourteenth Amendment was adopted in 1868 ... in only nine of the 37 states is it clear that there were statutes prohibiting assisting suicide." *Id.* In a footnote, the court did acknowledge that "Nevertheless, extrapolating from incomplete historical evidence and drawing inferences from states' treatment of suicide and from later historical evidence, Marzen hypothesized that in 1868, 'twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisting suicide.'" *Id.* at *69, n. 42.

What this rather disparaging note fails to make clear is that many of the U.S. states for many years after independence recognized and enforced not merely statutory crimes enacted by the legislature but also a court-made criminal law known as the common law of crimes. Some still do so today. So it is highly misleading in writing of the mid-Nineteenth Century to focus only on statutes without also asking whether particular states enforced the common law of crimes, and how that common law treated suicide. The court's textual reference to the nine states with statutes against assisting suicide gives a decidedly incomplete picture of the state of the law, which the inclusion of states in which it was a common law crime (making a total, with the statutory states, of 21 out of 37) corrects.

Second, in a truly striking example of taking something out of context, the Ninth Circuit quoted, implying it was typical, from one New Jersey court that in 1901 stated suicide was ethically defensible "when a man curtails weeks or months of agony of an incurable disease." *Id.* at *17, quoting *Campbell v. Supreme Conclave Improved Order Heptasophs*, 66 N.J.L. 274, 49 A. 550, 553 (1901).

This was the *only* American case quoted by the Ninth Circuit in all of its account of the legal history of suicide in America. Yet as we made clear in our article (and the court credits our article as the source of the *Campbell* quote), *Campbell* is "the *only* pre-1980 case we have found that articulates such a view [--] isolated not only in contrast to cases in other jurisdictions, but within New Jersey as well." Marzen, *supra* n. 7, at 84.

Campbell was an insurance case. Two years later, *State v. Carney*, 69 N.J.L. 478, 479, 55 A. 44, 45 (Sup. Ct. 1903), upheld a conviction for attempting suicide, criticizing *Campbell* and writing, "Suicide is none the less criminal because no punishment can be inflicted.... If one kills another, and then kills himself, is he any less a murderer because he cannot be punished?" Then, in 1922, New Jersey's highest court (despite its name, the New Jersey Supreme Court in 1901 was an inferior court) wrote, "So strong is this concern of the state [in 'the preservation of the life of each of its citizens'] that it does not even permit a man to take his own life...." *State v. Ehlers*, 98 N.J.L. 236, 238, 119 A. 15, 17 (1922).

More to the point, our article cited literally hundreds of cases throughout the Nineteenth and Twentieth Centuries in an effort to give a comprehensive account of the historical attitude of American law toward suicide. As the article painstakingly demonstrates, the *Campbell* decision was distinctly at odds with them. To pluck out the one anomalous case and present it alone in a manner designed to suggest to the unwary

Thus, history and legal precedent does not support the notion that now or in the past suicide has been treated as an accepted freedom or liberty in the United States. It follows that no argument can successfully be made that laws preventing assisting suicide are unfair, irrational, or discriminatory.

CONCLUSION

Efforts to legalize assisting suicide, such as those embodied in the Second and Ninth Circuit decisions, will if successful pose an unacceptable threat to vulnerable members of our society who have never asked to die but who will be subject to nonvoluntary euthanasia at the hands of surrogates. There is a strong rational basis for the distinction now drawn in American law between rejection of treatment and the taking of direct action to end life, and there is no basis for the claim that suicide or attempted suicide has been or is now treated by the law as a freedom or protected liberty.

reader that it is representative of the American law of suicide simply cannot be squared with standards of scholarly integrity.

APPENDIX A:
 IMPLICATIONS OF THE SECOND CIRCUIT'S *QUILL V. VACCARO* RULING
 FOR NONVOLUNTARY EUTHANASIA

In *Quill v. Vaccaro*, 1996 WL 148605 (2nd Cir.(N.Y.)), the Federal Court of Appeals for the Second Circuit relied on the Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution to strike down, as applied, New York's statute protecting against assisting suicide.

In its summary of its analysis, the Second Circuit wrote:

[I]t seems clear that : 1) the statutes in question fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in question prohibit persons in the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.

Id. at *11.

Noting that the lower court identified "a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device," *Quill v. Koppell*, 870 F. Supp.78, 84 (S.D.N.Y. 1994), the Court of Appeals disagreed. It cited Justice Scalia as asserting "the irrelevance of the action-inaction distinction," *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296-97 (Scalia, J., concurring). It then insisted,

The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers. ... Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill, 1996 WL at *15.

The Second Circuit noted that "A finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest." *Id.* However, after reviewing the state interests advanced to justify laws preventing assisting suicide through direct killing, the court wrote, "The New York statutes prohibiting assisted suicide ... do not serve any of the state interests noted, in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment." *Id.* at *16. In effect, the second half of the inquiry essentially collapsed into the first, since any interest the state could possibly assert would be dismissed on the ground that, in the court's view, it would equally tell against rejection of treatment permitted by the state.

In short, since the Second Circuit could see no constitutionally supportable distinction between rejecting life-saving treatment and taking active measures to end life, it follows that whenever the state permits rejection of treatment, it must equally permit active killing.

The implications of this rationale extend beyond terminally ill, competent adults. In particular, in any state that authorizes surrogate decisionmakers to withdraw and withhold life-saving medical treatment from incompetent patients whose wishes are unknown, the rationale of the Second's Circuit decision will require that surrogates have an equal right to direct active measures to kill incompetent patients in like circumstances.

Limits in the Court Language?

The plaintiffs in *Quill* officially sought only the ability of doctors to prescribe lethal drugs for competent terminally ill patients who voluntarily request them, and, technically, the "holding" of the court applies only to that class of assisting suicide. Throughout its opinion, the Second Circuit couches its Equal Protection analysis in terms of the facts of this particular case: that is, it speaks of New York law that allows terminally ill, competent patients to reject treatment and compares that with the New York law preventing such patients from obtaining assistance in committing suicide.

However, nothing in this limits the force of the logic in the court's reasoning to terminally ill or indeed to competent patients. If drawing a line between rejecting treatment and direct killing is irrational and unconstitutional in the context of terminally ill competent patients, how can it suddenly be regarded as rational and constitutional in the context of incompetent patients or patients who are not terminally ill? The "irrationality," as the Second Circuit sees it, turns not on some issue unique to terminally ill or to competent patients, but rather on the lack of relevant difference between what the court sees as two alternative means (treatment withdrawal or lethal prescription) to the same end (intended death).

The law of New York permits essentially anyone to reject life-saving treatment if competent, and allows competent people to appoint health care agents to make such decisions on their behalf should they become incompetent. Under the Second Circuit's broad rationale, as distinct from its narrow holding, it is therefore difficult to see how

New York can place any limits on direct killing in any circumstances in which it does not equally place them on rejection of treatment.

The Second Circuit opinion does briefly discuss the question of nonvoluntary euthanasia:

As to the interest in avoiding abuse similar to that occurring in the Netherlands, it seems clear that some physicians there practice nonvoluntary euthanasia, although it is not legal to do so. ... The plaintiffs here do not argue for euthanasia at all but for assisted suicide for terminally-ill, mentally competent patients, who would self-administer the lethal drugs. It is difficult to see how the relief the plaintiffs seek would lead to the abuses found in the Netherlands.

Id. at *16 (citation and footnote omitted).

While it is true that the plaintiffs in this case only sought what the court describes as "assisted suicide for terminally-ill, mentally competent patients," the *reasoning* the court employed in order to grant them that "relief" is not so limited. It is not so much the "relief the plaintiffs seek" as the reasoning that allows no distinction between withholding treatment and administering lethal agents that threatens "nonvoluntary euthanasia." And it does so if a state permits a surrogate to reject life-saving treatment

for an incompetent patient whose wishes are not clear.

New York law does not currently provide such authority. However, New York's legislature is now considering a bill (S.5020/A.6791) that would establish surrogate decisionmaking in New York, and the *majority view* of the courts among states that have dealt with the issue supports surrogate decisionmaking. If upheld by the U.S. Supreme Court, the reasoning of *Quill v. Vaccaro* will apply to require equal authority for a surrogate to direct death by means of a lethal agent.

APPENDIX B

STATES WHOSE COURTS HAVE FOUND A CONSTITUTIONAL RIGHT
TO SURROGATE DENIAL OF TREATMENT FOR INCOMPETENT PATIENTS

Courts have found a constitutional right for surrogates to deny life-saving medical treatment for their incompetent wards in the following fourteen (14) states as of April 29, 1996:

- Arizona:** *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 685-86 (1987);
- California:** *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, 852 (1988);
Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983);
- Connecticut:** *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713, 721 (1984);
- District of Columbia:** *In re A.C.*, 573 A.2d 1235, 1247 (D.C. 1990);
- Florida:** *In re Browning*, 568 So. 2d 4, 12 (Fla. 1990); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984);

Corbett v. D'Alessandro, 487 So.2d 368, 370 (Fla. Dist. Ct. App.),
review denied, 492 So. 2d 1331 (Fla. 1986); *In re Barry*, 445 So. 2d
 365 (Fla. Dist. Ct. App. 1984);

Georgia: *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984);

Indiana: *In re Lawrance*, 579 N.E.2d 32, 39 (Ind. 1991);

Louisiana: *In re P.V.W.*, 424 So.2d 1015, 1019 (La. 1982);

Massachusetts: *In re Beth*, 412 Mass. 188, 587 N.E.2d 1377, 1382 (1992); *In re Doe*,
 411 Mass. 512, 583 N.E.2d 1263, 1267 (1992); *Brophy v. New
 England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626, 633
 (1986); *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982);
In re Spring, 380 Mass. 629, 405 N.E.2d 115, 119 (1980);
Superintendent of Belchertown State School v. Saikewicz, 373 Mass.
 728, 370 N.E. 2d 417, 427-28 (1977); *In re Hier*, 18 Mass. App. 200,
 464 N.E.2d 959, *review denied*, 392 Mass. 1102, 465 N.E.2d 261
 (1984);

Minnesota: *In re Torres*, 357 N.W.2d 332 (Minn. 1984);

New Jersey: *In re Jobes*, 108 N.J. 394, 529 A.2d 434, 451 (1987); *In re Peter*, 108 N.J. 365, 529 A.2d 419, 423 (1987); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 664 (1976); *In re Clark*, 210 N.J. Super. 548, 510 A.2d 136 (Ch. Div. 1986); *In re Visbeck*, 210 N.J. Super. 527, 510 A.2d 125, 129 (Ch. Div. 1986);

Ohio: *In re Crum*, 61 Ohio Misc. 2d 596, 580 N.E.2d 876 (Probate Ct. Franklin County, 1991); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980);

Washington: *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 449 (1987), *modified*, 757 P.2d 534 (1988); *In re Ingram*, 102 Wash. 2d 827, 689 P.2d 1363 (1984); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 744 (1983); and

Wisconsin: *In re L.W.*, 167 Wis. 2d 53, 482 N.W.2d 60, 67 (1992).

STATEMENT OF THE CHRISTIAN MEDICAL & DENTAL SOCIETY

Bristol, TN

Introduction

The Christian Medical & Dental Society serves as a voice and ministry for Christian doctors. Its mission is to “change the heart of healthcare.” Founded in 1931 and today serving 11,000 members, CMDS promotes positions on health care issues; conducts overseas and domestic mission projects; coordinates a network of Christian doctors for fellowship and professional growth; sponsors student chapters in medical and dental schools; distributes educational and inspirational resources; holds marriage and family conferences; provides Third World missionary doctors with continuing education resources; and conducts academic exchange programs overseas.

Overview

The membership of the Christian Medical & Dental Society (CMDS) has by vote officially declared its opposition to physician-assisted suicide (*see Appendix A*). CMDS opposes physician-assisted suicide for the following reasons:

1. It violates the Hippocratic and Judeo-Christian ethics that have provided the foundation of medicine for thousands of years.
2. Precedents in pre-war Germany and modern day Holland evidence an insidious link between physician-assisted suicide, genocide, involuntary euthanasia, and infanticide.
3. Economic pressures will translate the “right to die” into the “duty to die,” putting the elderly, handicapped, poor and others at particular risk.
4. Hospices, pain management and truly compassionate, loving care offer ethical alternatives to killing the patient.

Ethical Foundations

In ancient Greece and Rome, patients never knew if their physician would heal them or kill them. Especially vulnerable to euthanasia were the elderly, disabled, seriously sick, and weak infants. The followers of Hippocrates articulated life-honoring principles that came to be known as the Hippocratic oath (circa 400 B.C.): “I will keep [the sick] from harm and injustice. I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.”

CMDS member Robert Orr, MD, chairman of medical ethics at Loma Linda University, has observed, “Killing patients has been outside the bounds of medical care for at least 2500 years. . . . Making this a possibility would change the very character of the practice of medicine. The physician would no longer be purely a healer, but would be an executioner as well. This would seriously undermine the doctor-patient relationship and the trust that is so necessary to that relationship. In addition, I believe it would also detract from our current efforts in palliative care.

... If patients and doctors had the easy option of euthanasia, there would be much less effort placed into good end-of-life care."¹

Besides sympathy with many of the ideals of the Hippocratic oath, many doctors practicing today hold to a Judeo-Christian perspective on life. A cornerstone of the Judeo-Christian stance is the commandment, "Thou shalt not murder." John Jefferson Davis contrasts the Judeo-Christian standard with the relativistic viewpoint:

"The euthanasia mentality sees man as the lord of his own life; the Christian sees human life as a gift from God, to be held in trusteeship throughout man's life on earth. . . . Determining the moment of death is God's prerogative, not man's (Job 14:5). Man does not choose his own death, but acquiesces in the will of the heavenly Father, knowing that for the believer, death is both the last enemy, and the doorway to eternal life. Because man bears the image of God, his life is sacred in every state of its existence, in sickness or in health, in the womb, in infancy, in adolescence, in maturity, in old age, or even in the process of dying itself."²

Precedents

In the past half decade, the Hippocratic and Judeo-Christian foundations of medicine have been eroded. CMDS member and former surgeon general C. Everett Koop notes, "I am convinced that in the 1930's the German medical sentiment favoring euthanasia (even before Hitler came to power) made it easier for the Nazi government to move society along the slippery slope that led to the Holocaust."³

Holland has allowed physician-assisted suicide for over a decade, with supposedly strict controls. An official Dutch government survey revealed that in 8,100 cases in which doctors prescribed lethal overdoses of pain medication, *61 percent of the patients had not consented to their death.*⁴ According to a *U.S. News and World Report* article, in 45 percent of cases of involuntary euthanasia in hospitals, doctors did not even consult family members.⁵ Dutch government officials are now "resorting to the courts to build precedents that would serve as unofficial policy governing the mercy killing of newborns."⁶

Practical considerations

Managed care is placing increasing pressures on and even offering financial rewards to doctors to limit patient treatment. Seriously ill patients will be made to feel like financial and emotional

¹ Robert Orr, MD, *Physician-Assisted Death*, in *New Issues in Medical Ethics*, Jay Hollman, MD, editor (Bristol, TN: Christian Medical & Dental Society), p. 184.

² Davis, John Jefferson, *Evangelical Ethics*. (Phillipsburg, NJ: Presbyterian and Reformed Publishing Co., 1985), pp. 191-92.

³ C. Everett Koop, MD and Timothy Johnson, MD, *Let's Talk* (Grand Rapids, MI: Zondervan, 1992), p.46.

⁴ Van der Maas PJ, van Delden JJM, Pijnenborg L, Looman CWN. "Euthanasia and other medical decisions concerning the end of life: An Investigation Performed Upon Request of the Commission of Inquiry into the Medical Practice Concerning Euthanasia," (Amsterdam: Elsevier Science Publishers, 1992), p. 73.

⁵ *U.S. News & World Report*, April 25, 1994, pp. 31-36.

⁶ Associated Press wire story, December 5, 1995.

burdens. The poor, elderly, disabled, disadvantaged and others lacking access to medical care will be at greatest risk. For them, the 'right to die' can quickly become a 'duty to die.'

CMDS members Orr, Schiedermayer and Biebel list a few other practical considerations:

Abuse. Once it is considered right to end someone's life on request, it will be much easier to presume a "request" from others (the demented, comatose, etc.).

Error. The inherent uncertainties in medicine will cause some to die unnecessarily.

Slippery slope. Once society accepts voluntary euthanasia, it can be predicted that very quickly allowance will have to be made for those who are unable to speak for themselves.

Distrust. If the patient knows his doctor is allowed to kill him, there will be an erosion of the traditional trust between patient and doctor.

Coercion. Elderly, handicapped, and dying people may feel subtly or directly encouraged to request their legal option of euthanasia.⁷

True Compassion and Hope

True compassion involves coming alongside someone who is suffering with the purpose of helping--not killing. Compassion often involves a course of difficult sacrifice, as the helper shares in the problems and pain of the patient.

Physician-assisted suicide is the easiest way out. Though often couched in terms of compassion and caring, it requires neither a commitment to care nor love. Even if one were purely motivated to relieve suffering, a 'merciful' motive could not justify an immoral act.

The vast majority of terminally ill patients who experience pain can receive treatment that significantly reduces their discomfort. It would be severely short-sighted to legalize physician-assisted suicide in order to address the exceptional minority for whom pain treatment is inadequate.

Still, controlling and relieving pain is not the lone factor contributing to suicidal desires. Depressed patients and those who feel fatigued from battling long-term illnesses may simply feel that "life is no longer worth living." These individuals do not need our encouragement to kill themselves; they need a *reason to live*. Their problem is not ultimately physical, but emotional, moral and spiritual. They do not need a lethal prescription; they need *hope and love*.

As Dr. Koop has observed, "... our spiritual heritage reminds us that we should not equate being *terminally* ill with being *hopelessly* ill."⁸ He warns, "... I am very fearful about placing

⁷ Robert Orr, MD, David Schiedermayer, MD, and David Biebel, D. Min, Life & Death Decisions: Help in Making Tough Choices about Bioethical Issues (Colorado Springs: Baker Book House, 1990), p. 158.

⁸ Koop and Johnson, p.46.

societal pressure or family pressure on terminally ill people to 'hurry up and move out of the way.'"⁹

Beth Spring and Ed Larson have noted, "Beyond hospice care, there is a broader need in society to recognize and meet the challenges of a growing elderly population. Restoring respect, building community awareness, and promoting cross-generational activities and ministry opportunities are all part of this bigger picture."¹⁰ They explain, "Euthanasia is virtually irrelevant in circles where the elderly have high self-esteem, a sense of purpose, and a close community. As these circles widen and multiply nationwide through the work of churches and other institutions dedicated to preserving life from start to finish, the grip of the appeal euthanasia holds may slowly be loosened."¹¹

Hospice care and pain control technology offer alternatives to suicide. Both depression and pain can be treated, providing the patient with a great measure of relief. Hospice care offers dying with dignity and fulfills the true meaning of compassion—coming alongside the sufferer. The loving care of friends and family can bring great dignity and immeasurable value to the lives of terminally ill patients.

Conclusion

Physician-assisted suicide is merely a cheap, quick-fix alternative to treating and caring for suffering patients. It has no roots in the ethical foundations that have moored medicine and society for thousands of years. Both the recent past and the present evidence the deadly slippery slope down which physician-assisted suicide leads. Given economic and other pressures, under legalized assisted suicide the "right to die" would soon become the "duty to die."

Rather than opening the door to killing patients, we must focus on coming alongside them with true compassion. We must demonstrate by our loving care that life—even in its most difficult stages—is *worth living*. We must resist the temptation to rid ourselves of "burdens" and instead offer hope and love to individuals who are inherently of *immeasurable worth*.

⁹ Ibid., p.55.

¹⁰ Beth Spring and Ed Larson, Euthanasia: Spiritual, Medical, and Legal Issues in Terminal Health Care (Portland: Multnomah Press, 1988), p. 189.

¹¹ Ibid., p. 192.

Appendix A

CMDS Position Statement on Physician-Assisted Suicide

We, as Christian physicians and dentists, believe that human life is a gift from God and is sacred because it bears God's image. Human life has worth because Christ died to redeem it, and it has meaning because God has an eternal purpose for it.

We oppose active intervention with the intent to produce death for the relief of pain, suffering, or economic considerations, or for the convenience of patient, family, or society.

Proponents of physician-assisted suicide argue from the perspective of compassion and radical individual autonomy. There are persuasive counter arguments based on the traditional norms of the medical professions and the adverse consequences of such a public policy. Even more important than these secular arguments is the biblical view that the sovereignty of God places a limit on human autonomy.

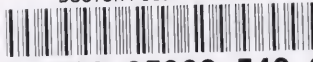
In order to affirm the dignity of human life, we advocate the development and use of alternatives to relieve pain and suffering, provide human companionship, and give opportunity for spiritual support and counseling.

The Christian Medical & Dental Society opposes physician-assisted suicide in any form.¹²

¹² Approved by the CMDS House of Delegates. Passed unanimously May 1, 1992. St. Louis, Missouri.



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